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COMPOSITE INDEX
AND
CUMULATIVE SUPPLEMENT

CLINICAL PEDIATRICS

COMPOSITE INDEX
AND
CUMULATIVE SUPPLEMENT

VOLUME XXI

ILLUSTRATED

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PUBLISHERS' ANNOUNCEMENT

With the completion of the Clinical Pediatrics series, the General Practitioner has access to a well-balanced library covering this important field, and while it is for this class that the work is primarily intended, as emphasized by each author in his preface, there is a further measure of accomplishment resulting from the method used by the various authors in covering the subjects assigned to them.

A number of the authors have seen fit to write concise monographs which, while carefully conforming to the general scheme, are complete in themselves and by no means limited in their scope to the infant and child; others have covered more general subjects and confined their discussion more definitely to the early years of life. The complete work is a pleasing combination of the two styles of presentation.

Pediatricians and Obstetricians, to whom the man in general practice refers his more stubborn cases and who appreciate the necessity of keeping informed as to the trend of postgraduate education, find in Clinical Pediatrics a mine of clearly presented facts enabling them to appreciate their function as consultants—for it behooves them, as *specialists,* to know where the family physician feels his limitations if they are to deserve his confidence.

The Composite Index, constituting the first part of this volume, needs no comment. It will be found entirely adequate for ready reference and especially valuable where, occasionally, a subject has been touched upon by more than one author. Time devoted to a study of its style and scope will be amply repaid by the advance information thus obtained of the mass of material available in the series.

The section devoted to supplementary material represents contributions from several of the authors and covers developments along various lines since publication of the original manuscripts. This device is desirable and, in a field of such activity as that of pediatrics, quite essential. Much of this material will eventually find its way into the respective volumes, and in the meantime the practitioner is provided with reviews of recent developments, sublimated by the judgment of well-known authorities.

The reception accorded Clinical Pediatrics prior to publication of the complete series, testifies to the care with which it was planned and the caliber of the authors. Reviews of the various volumes as they appeared have been uniformly good. The practitioner will find here an adjunct—a dependable assistant—whether for quick reference or for leisurely study.

CONTENTS

PAGE

Publishers' Announcement v

Composite Index 3

CUMULATIVE SUPPLEMENT

The Newborn—Physiology and Care 301
  Introduction 301
    Effects of Radiotherapy on Fetus 301
    Mortality and Morbidity 302
    Predisposition to Disease 303
  Anatomy and General Physiology 303
    Anatomy 303
    Chemistry 304
    Initial Weight Loss 304
  Physiology of the Blood 305
    Biologic Properties of Blood 305
    Icteric Index 306
    Inorganic Blood Phosphorus 306
    Leukocytes 307
    Blood Platelets 307
    Erythrocytes 307
  The Stools 307
    Classification 307
    Blood in Stools 308
    Bacteriology of Stools 308
  Metabolism 309
    Carbohydrate Metabolism 309
    Synthesis of Fats 309
    Insensible Perspiration 309
  Secretions 310
    Cerebrospinal Fluid 310
  Physiology of the Urine 310
  Physiology of the Nervous System 311
    Embrace Reflex 311
    Conditioned Reflex 311
    Chvostek Phenomenon 311
  Feeding 312
    Importance of Water 312
    Density of Curd 312
    Lactic Acid Milk 312
    Dried and Evaporated Milks 312
    Antirachitics 313
  Prematurity and Congenital Debility 313

PAGE
- Estimation of Fetal Age 313
- Blood Counts 314
- Low Birth Weight 314
- Fate of Premature 314
- Feeding 316
- Antirachitis 316
- Asphyxia 317
  - Drug Therapy 318
  - Electrical Stimulation 318
- Cyanosis 318
  - Limited or Localized Cyanosis 318
- Transitory Fever 319
- Icterus 319
  - Hematogenous Origin 319
  - Theories 320
  - Incompatibility 320
  - Icterus Gravis 320
- Hemorrhagic Disease of the Newborn 321
  - Relation of Anesthetics to Bleeding 321
  - Relation of Asphyxia to Bleeding 321
  - Prophylaxis 321

THE NEWBORN—DISEASES AND ABNORMALITIES 325
- Winckel's Disease 325
- Infectious Diseases 325
  - Immunity 325
  - Characteristics of Infection 326
  - Sepsis Neonatorum 326
  - Erysipelas 327
  - Smallpox 327
  - Diphtheria 327
  - Measles 328
  - Scarlet Fever 328
  - Influenza 329
  - Gonococcus Infections 329
  - Tetanus Neonatorum 330
  - Congenital Malaria 330
  - Kala-azar 330
  - Typhoid 330
- Syphilis 331
  - Pathology 331
  - Diagnosis 332
  - Treatment 332
- Tuberculosis 333
  - Prophylactic Vaccination 333
- The Respiratory System 334
  - Congenital Stridor 334
- Bronchi and Lungs 335
  - Malformations 335
  - Injuries and Hemorrhages 335
  - Pneumonia Neonatorum 335

PAGE
  Tumors of the Bronchi and Lungs 336
  The Pleura 337
Cardiovascular System 337
  Roentgenological Studies 337
  Congenital Heart Disease 337
  Ectopia Cordis Pectoralis 338
  Idiopathic Congenital Hypertrophy 338
  Congenital Atresia of the Foramen Ovale 339
  Hematomas of the Heart Valves 339
  Congenital Heart Block 339
  Congenital Transposition of the Cardiac Vessels 339
  Pericardium 340
The Blood 340
The Spleen 341
The Digestive System 342
  Congenital Anomalies of the Tongue 342
  Congenital Atresia of the Esophagus 342
  Congenital Pyloric Stenosis 342
  The Small Intestine and Colon 343
  Congenital Microcolon 343
  Diverticulum of the Intestine 343
  Epithelial Heterotopia 343
  Ventral Hernia 344
  Diaphragmatic Hernia 344
  Cardiospasm 344
  Hemorrhage 345
  Injuries 345
  The Liver 346
The Nervous System 346
  Malformations 346
  Obstetric Paralysis 347
  Congenital Facial Paralysis 347
  Intracranial Hemorrhage 347
  Meningitis 348
  Encephalitis 349
  Cerebral Birth Paralysis 349
  Cranial Nerve Palsies 350
  Microcephaly 350
  Amaurotic Family Idiocy 350
  Mongolian Idiocy 350
The Genito-Urinary Tract 351
  Congenital Abnormalities 351
  Pyelitis 351
  Tumors 352
The Bones and Joints 352
  Skull 352
  The Trunk 353
  Cleidocranial Dysostosis 353
  Arachnodactylia 354
  Congenital Contractures 354
  Congenital Dislocation 354

PAGE
Osteogenesis Imperfecta 354
Chondrodystrophia Fetalis 354
Congenital Hypertrophy 354
The Skin 355
Livedo Reticularis 355
Impetigo Contagiosa Bullosa (Pemphigus Neonatorum) . . 355
Fat Necrosis 356
Favus 356
Gangrene of the Skin 356
The Eye 356
The Ductless Glands 357
Thymus Gland 357
Thyroid Gland 358
Suprarenal Gland 358

PREVENTIVE PEDIATRICS 364

DISEASES OF THE DIGESTIVE SYSTEM 365
Hirschsprung's Disease 365
New Methods of Treatment 366
Recurrent Vomiting of the Cyclic Type 367
Chronic Ulcerative Colitis 369
Vomiting of Functional Origin in Newborn Infants 369
Common Method of Infestation with Intestinal Parasites . . . 370

DISEASES OF THE BLOOD AND BLOOD-BUILDING ORGANS 372
Methods of Blood Examination 372
Oxidase Stain 372
Blood Grouping 372
Blood Pictures in Diseases outside of the Hematopoietic System . 373
Chronic Infectious Diseases 373
Secondary Anemia Treatment 374
Intraperitoneal Transfusion 374
Iron Therapy 375
Idiopathic Anemias 375
Pernicious Anemia 375
Idiopathic Anemia of the Newborn 376
Anemias Associated with Disturbances of the Spleen and Lymph-Nodes 377
Splenic Anemia 377
Gaucher's Disease and Niemann-Pick's Disease 378
Leukemias without Leukocytosis 379
Diagnosis 379
The Chloromata 384
Diagnosis 384
Treatment 384
The Purpurata 384
Treatment of Idiopathic Thrombopenic Purpura (Purpura Hæmorrhagica) 384

COMPOSITE INDEX

COMPOSITE INDEX

Abbott frame, scoliosis and, vi, 268
Abdomen, binders of, delivery and, i, 32, 131
— causes of obscure pain in, viii, 269
— contusions of, significance of, xv, 296
— — treatment of, xv, 297
— distention of, abruptio placentae and, i, 55
— examination of, i, 160; viii, 267
— fetal death in utero and, i, 50
— newborn, proportions of, ii, 29
— — size of, ii, 12
— pain in, danger signal, i, 169
— surgery of, abdominal tuberculosis, xv, 302
— — acute intussusception, xv, 313
— — appendicitis, xv, 305
— — congenital hypertrophic pyloric stenosis, xv, 283
— — contusions, xv, 296
— — developmental errors of gastro-intestinal tract, xv, 272
— — enteric cysts, xv, 339
— — examination of, xv, 6
— — intestinal obstruction, xv, 320
— — jaundice in sepsis of newly born, xv, 311
— — liver and bile-ducts, xv, 330
— — megacolon, xv, 322
— — omental and mesenteric cysts, xv, 338
— — pancreatitis, xv, 334
— — peritonitis in infants and young children, xv, 299
— — peritonitis in newly born, xv, 298
— — pyloric stenosis, xv, 283
— — retroperitoneal abscess, xv, 311
— — sarcoma of intestine, xv, 339
Abdomen, surgery of, splenic anemia and Gaucher's disease, xv, 335
— — tumors of ovary, xv, 337
— — umbilical affections, xv, 281
— tuberculosis of, xv, 302
Abdominal binder, ii, 124
Abdominal distention, atresia of intestine causing, iii, 149
Abdominal heart, iii, 104
Abdominal pain, acute rheumatic fever causing, xviii, 54
Abdominal purpura, diagnosis of, viii, 274
— symptoms of, viii, 273
— treatment of, viii, 274
Abdominal reflex, ii, 113; v, 11
Abdominal support, cyclic vomiting treated by, viii, 138
Abdominal tuberculosis, complications of, viii, 283
— diagnosis of, viii, 282
— etiology of, viii, 277
— general survey of, viii, 276
— intestinal lesions of, viii, 279
— mesenteric lesions of, viii, 280
— occurrence of, viii, 277
— pathogenesis of, viii, 277
— peritoneal lesions of, viii, 280
— prognosis of, viii, 284
— symptoms of, viii, 280
— treatment of, viii, 284
Abdominal viscera, ectopia of, iii, 156
Abnormal development and growth, dwarfism, xiii, 147
— exogenous obesity, xiii, 137
— fragilitas ossium, xiii, 164
— infantilism, xiii, 145
— Lorraine infantilism, xiii, 145
— malnutrition, xiii, 139
— microcephalus, xiii, 164

In lieu of index of Supplement beginning on page 301, the reader is referred to the detailed Table of Contents in the first part of this volume.

Abnormal development and growth, mongolism, xiii, 153
— obesity, xiii, 137
— osteomalacia and osteogenesis imperfecta, xiii, 164
— osteopsathyrosis, xiii, 164
— progeria, xiii, 162
— true infantilism, xiii, 145
Abnormal obstetrical cases, care of, i, 154
— hospital service for, i, 158, 162
Abnormalities, congenital, adenoma sebaceum, xvi, 22
— — epidermolysis bullosa, xvi, 18
— — ichthyosis, xvi, 13
— — keratosis palmaris et plantaris, xvi, 17
— — multiple benign cystic epithelioma, xvi, 27
— — neurofibromatosis, xvi, 25
— — nevi, xvi, 1
— — Recklinghausen's disease, xvi, 25
— — syringocystoma, xvi, 28
— — urticaria pigmentosa, xvi, 28
— — xeroderma pigmentosum, xvi, 19
— fetal causes of, i, 67
— — percentage of, i, 49
— infant, care of, i, 137, 138, 149
— larnygeal, congenital, ix, 75
— multiple, prenatal factors in, v, 141
— pelvic, pregnancy and, i, 15, 18
— respiratory, ix, 88
Abortion, after-care, i, 28
— artificial, i, 6, 18, 29, 42
— cardiac cases and, i, 33
— criminal, i, 6, 45
— fibromyomata and, i, 42
— frequency of, iv, 106
— gonorrhea and, i, 61
— myomata and, uterine, i, 42
— ovariotomy and, i, 41
— patient's history of, i, 17
— prenatal care and, i, 2, 7, 12, 44-48
— retrodisplacements and, i, 20
— septic uterus following, treatment of, i, 90
— syphilis and, i, 78
— syphilis causing, iii, 40
— tubal infections and, i, 6
— tuberculosis and, i, 29
— tumors of uterus and, i, 42
Abortive cerebrospinal meningitis, xiv, 276
Abortive poliomyelitis, vi, 218; xiv, 240
Abrachia, cause of, vii, 55
Abruptio placentæ, hemorrhage and, i, 51
— placenta prævia differentiated from, i, 55
— prenatal care and, i, 52-56
— toxemia of pregnancy causing, i, 22
— treatment of, i, 56
— tumors of uterus and, i, 42
Abscesses, acute retropharyngeal, clinical features of, xv, 178
— — treatment of, xv, 179
— alveolar, pyelitis caused by, i, 36
— bone, clinical signs of, vii, 71
— — complications of, vii, 71
— — sequelæ of, vii, 73
— — treatment of, vii, 72
— — x-ray diagnosis of, vii, 72
— brain, accessory nasal sinus disease and, ix, 34
— — cerebrospinal fluid in, xx, 113
— breast, ii, 153
— Brodie's, vii, 71
— — clinical features of, xv, 139
— — syphilitic epiphysitis differentiated from, vii, 150
— — treatment of, xv, 140
— cerebral, epidemic encephalitis differentiated from, xiv, 261
— cold, paraplegia caused by, v, 123
— DuBois', iii, 59, 96, 379
— esophageal, pleurisy caused by, ix, 193
— gingival, viii, 13
— hepatic, pleurisy following, ix, 193
— ischiorectal, xv, 347
— lung, clinical course of, xv, 238
— — clinical features of, xv, 237
— — diagnosis of, xv, 238
— — etiology of, xv, 236
— — prognosis of, xv, 239
— — treatment of, xv, 239
— mediastinal, xv, 246
— multiple, of infants, xvi, 219

Abscesses, Munro's, psoriasis and, xvi, 128
— perianal, xv, 347
— perinephritic, i, 35
— — diagnosis of, xix, 175
— — etiology of, xix, 174
— perinephritic, incidence of, xix, 174
— — pyelitis and, xix, 174
— — symptoms of, xix, 175
— — treatment of, xix, 176
— peritonsillar, acute follicular tonsillitis causing, ix, 54
— — diagnosis of, ix, 65
— — etiology of, ix, 64
— — prophylaxis and, ix, 66
— — symptoms of, viii, 42; ix, 64
— — treatment of, viii, 42; ix, 65; xv, 180
— psoas, acute infectious arthritis and, vi, 60
— — acute infectious spondylitis and, vi, 62
— — hip-joint tuberculosis differentiated from, vi, 82
— — treatment of, vi, 66
— puerperal ulcer causing, i, 88
— pulmonary, iii, 86
— — bronchopneumonia and formation of, ix, 126, 130
— — characteristic appearance of sputum in, xx, 84
— — diagnosis of, ix, 175
— — etiology of, ix, 172
— — exploratory puncture in, ix, 174
— — foreign bodies causing, ix, 191
— — insufflation pneumonia causing, ix, 179
— — lobar pneumonia causing, ix, 160
— — pathology of, ix, 173
— — physical signs of, ix, 174
— — symptoms of, ix, 173
— — treatment of, ix, 176
— — tuberculosis differentiated from, xiv, 351
— — x-ray examination, ix, 175
— retroperitoneal, xv, 311
— retropharyngeal, diagnosis of, viii, 44; ix, 43
— — etiology of, ix, 42
— — symptoms of, viii, 43; ix, 42
Abscesses, retropharyngeal, treatment of, viii, 45; ix, 44
— retrotonsillar, ix, 64
— — acute follicular tonsillitis causing, ix, 54
— smallpox, xiv, 93
— spinal tuberculosis complicated by, vi, 88
— tuberculous "cold," xvi, 233
— — multiple abscesses of infants differentiated from, xvi, 219
— — treatment of, vi, 76
— typhoid bacilli causing, viii, 186
— urachal, xix, 18
— visceral, thrombophlebitis causing, i, 94
— vulvovaginal, gonorrhea and, i, 62
Absolute polycythemia, functional, case history of, xi, 216
— primary, blood-count in, xi, 219, 220
— — case history of, xi, 218
— — etiology of, xi, 218
— — treatment of, xi, 220
Absorption, carbohydrate, xii, 46
— fat, xii, 45
— food, intestinal, ii, 89
— gastric, newborn, ii, 87
— protein, xii, 52
— salt, xii, 53
— starch, xii, 49
— toxic intestinal, convulsions and, xii, 142
Acanthosis, blastomycosis showing, xvi, 199
— eczema showing, xvi, 117
Acanthosis nigricans, diagnosis of, xvi, 312
— etiology of, xvi, 312
— hyperpigmentation in, xvi, 285
— incidence of, xvi, 311
— keratosis follicularis differentiated from, xvi, 310
— prognosis of, xvi, 312
— symptoms of, xvi, 312
— treatment of, xvi, 312
Acaphia, labor and, i, 130
Acarodermatitis urticarioides, xvi, 159
Acarus folliculorum, xvi, 168
Acarus scabiei, xvi, 162, 165
Accessory food factors, x, 21

Accessory nasal sinuses, anatomy of, ix, 21
— disease of, ix, 21
— — chronic tonsillitis and, ix, 59
— — complications of, ix, 34
— — diagnosis of, ix, 32
— — etiology of, ix, 26
— — incidence of, ix, 31
— — pathology of, ix, 27
— — predisposing factors in, ix, 27
— — related affections, ix, 30
— — symptoms of, ix, 27
— — treatment of, ix, 35
— — x-ray technic in, ix, 31
— histology of, ix, 26
— newborn, iii, 66
— rheumatic infection and, xviii, 69
Accidental poisoning, acids, viii, 311
— alcohol, viii, 311
— alkalies, viii, 310
— arsenic, viii, 311
— aspidium, viii, 312
— atropin, viii, 312
— camphor, viii, 312
— chenopodium, viii, 312
— formaldehyd, viii, 313
— lead, viii, 313
— mercury, viii, 313
— opium, viii, 313
— phosphorus, viii, 314
— santonin, viii, 314
— silver nitrate, viii, 314
— turpentine, viii, 314
Accidents, labor, fetal and infant deaths due to, i, 7, 9
— — maternal deaths due to, i, 4
— — shock following, i, 130-135
Accommodation, paralysis of, diphtheria causing, v, 80
Accouchement forcé, i, 38
Accoucheurs, elimination of, i, 157
Acetarson, treatment of syphilis with, xvii, 265
Acetone, amount in blood, xx, 132
— urine and, ii, 107
Acetonuria, acidosis at labor and, i, 131
— fetal death in utero and, i, 50
— production of, x, 32
— significance of, xx, 10
— significance in newborn, xx, 3
Acetyl salicylic acid, acute follicular tonsillitis and, ix, 55
— acute pharyngitis and, ix, 41
— analgesic use of, respiratory diseases and, ix, 265
— antipyretic use of, respiratory diseases and, ix, 261
— headache and, ix, 36
— pleurisy and, ix, 194
— pleurisy with effusion and, ix, 198
— pollen fevers and, ix, 119
Achilles jerk reflex, ii, 113
Achillobursitis, orthopedic management of, vi, 217
Acholuric jaundice, blood changes in, xx, 61
— congenital, xi, 5
Achondroplasia, iii, 302, 305; vii, 11
— bodily changes in, vii, 19
— body growth and, vii, 14
— clinical features of, xv, 119
— diagnosis of, xiii, 151
— dwarfism and, x, 137
— etiology of, vii, 14
— metabolism in, xiii, 151
— morbid anatomy of, xiii, 147
— pathology of, vii, 14
— prognosis of, xiii, 152
— signs and symptoms of, xiii, 148
— treatment of, vii, 19; xiii, 152; xv, 120
— x-ray studies of, vii, 18
Achorion schœnleinii, xvi, 192
Achromia, definition of, xi, 15
Acid, accidental poisoning with, viii, 311
— acidosis caused by administration of, xiii, 33
— acidosis liberating, x, 269
— amino, protein the source of, x, 12
— β oxybutyric, carbohydrate deficiency and, x, 16
— carbonic, formation of, xiii, 26
— dermatitis caused by, xvi, 42
— diacetic, carbohydrate deficiency and, x, 16
— free hydrochloric, ii, 87
— glycocholic, ii, 92
— hydrochloric, protein digestion and, x, 37

Acid, keto, carbohydrate deficiency and, x, 16
— lactic, milk acidified with, x, 119
— oxalic, urine and, ii, 107
— taurocholic, ii, 92
— uric, excretion of, ii, 103
— — infarcts of, ii, 103
— — urine and, ii, 102
Acid-base equilibrium, disturbances of, acidosis, xx, 166
— — alkalosis, xx, 174
— Van Slyke's summary of possible variations in, xx, 169
Acid stools, alkalies for correction of, ix, 261
Acidified milk, buffer action and, xii, 20
— preparations of, xii, 36
Acidity, gastric, importance of, xx, 90
— pregnancy and, i, 165
— urinary, i, 21
Acidophilus milk, bacteriotherapy with, xx, 126
Acidosis, i, 130-133
— acids producing, x, 269
— administration of acids causing, xiii, 33
— alkali therapy in, x, 273
— carbohydrate deficiency and, x, 16
— classification of, xx, 166
— definition of, xx, 166
— diabetes mellitus and, xiii, 101
— diarrheal diseases and, xiii, 31
— disease and, ii, 171
— etiology of, x, 268
— glucose in treatment of, x, 273
— hydrogen-ion concentration of blood in, xx, 167
— incidence of, xv, 24
— ketosis causing, xx, 170
— ketosis-, conditions associated with, xiii, 28
— — pathological physiology of, xiii, 27
— — symptoms of, xiii, 28
— — treatment of, xiii, 29
— laboratory tests for, x, 271
— loss of alkali causing, xx, 172
— measurement of alkali tolerance as test for, x, 272
— nephritis and, x, 173
Acidosis, occurrence of, x, 268, 271
— pathological physiology of, xiii, 25
— physiologic in newborn, ii, 98
— potential in newborn, ii, 99
— prognosis of, xv, 25
— renal, xiii, 31
— respiratory diseases and, diet in, ix, 256
— symptoms of, x, 270; xx, 170
— treatment of, i, 131; x, 273
— types of, xiii, 26, 31
— water administration in, x, 274
— whooping-cough and, xiv, 126
Acidulated milk, iv, 54
Acinal epithelium, ii, 140
Acne, papular, granulosis rubra nasi, differentiated from, xvi, 278
— smallpox differentiated from, xiv, 95
Acne bacillus of Unna, xvi, 281
Acne neonatorum, xvi, 280
Acne vulgaris, diagnosis of, xvi, 281
— etiology of, xvi, 280
— pathology of, xvi, 280
— prognosis of, xvi, 282
— symptoms of, xvi, 280
— treatment of, xvi, 281
Aconite, dermatitis caused by, xvi, 48
Acquired asphyxia, ii, 201
Acquired atelectasis, iii, 88
Acquired cardiovascular disease, iii, 117
Acquired goiter, surgery of, xv, 200
Acquired heart disease, newborn, iii, 117
— prevention of, iv, 126
Acquired immunity, xiv, 5
Acquired intestinal obstruction, iii, 196
Acquired syphilis, congenital syphilis distinguished from, iii, 38
— general considerations of, xvii, 233
— incidence of, xvii, 241
— lupus vulgaris differentiated from, xvi, 228
— pathology of, xvii, 41
— prognosis of, xvii, 257
— significant peculiarities of, xvii, 240
— treatment of, results of, xvii, 284
Acquired umbilical hernia, iii, 158
Acrania, anatomy of, vii, 53

Acro-asphyxia, congenital, ii, 196
Acrocephaly, v, 52; vii, 54
Acrodynia, diagnosis of, x, 280; xiii, 135
— etiology of, x, 276, 278; xiii, 134
— pathology of, x, 278
— symptoms of, x, 277; xiii, 134
— teeth and, viii, 64
— treatment of, x, 281; xiii, 136
Acromegaly, abnormal pituitary function and, xiii, 77
— giantism and, x, 146
— hyperpituitarism and, xiii, 22
Acromion reflex, ii, 113
Actinomycosis, diagnosis of, xvi, 197
— etiology of, xvi, 197
— pathology of, xvi, 197
— pharyngeal, viii, 40
— prognosis of, xvi, 197
— symptoms of, xvi, 196
— treatment of, xvi, 197
Actinotherapy, action of light on pathogenic microörganisms, vii, 218
— composition of light, vii, 217
— general irradiation, vii, 230
— Grotthus' law and, vii, 219
— physiology of photochemical action, vii, 220
— respiratory diseases and, ix, 260
— results of exposure to mercury-vapor-quartz-lamp, vii, 229
— sunlight and artificial light compared, vii, 219
— types of ultraviolet lamps, vii, 228
— use of carbon-arc lamp, vii, 231
Active hyperemia, xvi, 57
Active motion, orthopedic examination by, vi, 8
— — sacro-ileac joint and, vi, 21
— — spine and, vi, 23
— — Willems', acute infectious arthritis and, vi, 55
Acton, syphilis described by, xvii, 8
Acuminate wart, xvi, 319
Acute anterior poliomyelitis, v, 102
— acute syphilitic epiphysitis differentiated from, vii, 150
— cause of, iv, 141
— cerebrospinal fluid in, xx, 115
— clinical course of, vi, 218
Acute anterior poliomyelitis, diagnosis of, vii, 243
— etiology of, vi, 218; vii, 241
— hip-joint dislocation following, vi, 60
— infective nature of, v, 103
— Little's disease differentiated from, vi, 239
— onset of, vii, 240
— operative measures for correction of deformity, vi, 228
— orthopedic management of, vi, 218
— orthopedic treatment of, v, 107
— pathology of, vi, 218; vii, 241
— prognosis of, vi, 225
— progressive muscular atrophy differentiated from, vi, 247
— reflexes in, v, 104
— scurvy differentiated from, vii, 213
— stages of, v, 104
— symptoms of, v, 104; vi, 218; vii, 241
— synonyms of, xiv, 224
— treatment of, v, 105; vi, 226; vii, 244
Acute appendicitis, affections mistaken for, viii, 254
— anatomy of, viii, 250
— clinical features of, xv, 306
— diagnosis of, viii, 253
— differential diagnosis of, xv, 307
— etiology of, viii, 249
— incidence of, xv, 305
— lobar pneumonia differentiated from, ix, 157, 159
— pathology of, viii, 250
— prognosis of, viii, 255
— symptoms of, viii, 251
— treatment of, viii, 255; xv, 308
Acute arthritis, acute follicular tonsillitis causing, ix, 54
Acute articular rheumatism, acute osteomyelitis differentiated from, vii, 70
— complications of, vii, 95
— diagnosis of, vii, 95
— etiology of, vii, 90
— pathology of, vii, 92
— prognosis of, vii, 98
— scurvy differentiated from, xiii, 125
— symptoms of, vii, 92

Acute articular rheumatism, synonyms of, xiv, 388
— treatment of, vii, 97
Acute asthmatic bronchitis, ix, 109
Acute atrophic paralysis, vii, 240
Acute bronchitis, blood-count in, xi, 47
— character of cough of, ix, 99
— complications of, ix, 104
— diagnosis of, ix, 104
— etiology of, ix, 102
— incidence of, ix, 101
— pathology of, ix, 102
— prognosis of, ix, 104
— prophylaxis of, ix, 106
— symptoms of, ix, 103
— treatment of, ix, 105
Acute bronchopneumonia, abscess formation in, ix, 126
— acute congestive stage of, ix, 124
— bronchial glands in, ix, 126
— character of cough in, ix, 128
— complications of, ix, 130
— diagnosis of, ix, 131
— distribution of lesions in, ix, 124
— emphysema associated with, ix, 126
— end results of, ix, 126
— etiology of, ix, 121
— gangrenous areas in, ix, 126
— glandular involvement in, ix, 126
— gray stage of, ix, 125
— incidence of, ix, 121
— lobar pneumonia differentiated from, ix, 154
— mottled red and gray stage of, ix, 125
— pathology of, ix, 122
— primary form of, ix, 129
— — incidence of, ix, 122
— prognosis of, ix, 131
— prophylaxis of, ix, 136
— respiration in, ix, 128
— secondary form of, ix, 130
— stages of, ix, 124
— symptoms of, ix, 127
— temperature in, ix, 127, 133
— treatment of, ix, 134
Acute cardiac dilatation, iii, 105
Acute catarrhal bronchitis, ix, 101
Acute catarrhal fever, ix, 1
Acute catarrhal gastritis, pathology of, viii, 104
— symptoms of, viii, 105
— treatment of, viii, 105
Acute catarrhal pharyngitis, treatment of, viii, 39
Acute cervical adenitis, surgery of, xv, 189
Acute circumscribed edema, xvi, 76
Acute dysentery, course of lesions of, viii, 175
— description of, viii, 173
— diagnosis of, viii, 178
— etiology of, viii, 173
— lesions of, viii, 174
— prognosis of, viii, 179
— prophylaxis of, viii, 182
— symptoms of, viii, 176
— treatment of, viii, 180
Acute edema of uvula, treatment of, ix, 48
Acute endocarditis, acute osteomyelitis differentiated from, vii, 70
— blood-count in, xi, 47, 49
Acute enteritis, cerebrospinal meningitis differentiated from, xiv, 281
Acute epidemic infectious adenitis, synonyms of, xiv, 314
Acute epididymitis, xv, 371
Acute epiphysitis, diagnosis of, vii, 70
— differential diagnosis of, vii, 149
— hip-joint dislocation and, vii, 60
— osteomyelitis and, vii, 69; xv, 137
— symptoms of, vii, 69
Acute exanthemata, blood-count in, xi, 47
Acute fasting, symptoms of, xiii, 24
— treatment of, xiii, 24
Acute fatty degeneration, atelectasis caused by, iii, 88
— blood changes in, xx, 52
Acute focal glomerulonephritis, hematuria caused by, xix, 69
Acute follicular tonsillitis, complications of, ix, 54
— diagnosis of, viii, 47; ix, 53
— diphtheria differentiated from, xiv, 168
— etiology of, ix, 51
— pathology of, ix, 51

Acute follicular tonsillitis, prophylaxis of, ix, 54
— scarlet fever differentiated from, xiv, 19
— symptoms of, viii, 46; ix, 52
— treatment of, viii, 47; ix, 54
Acute glomerular (hemorrhagic) nephritis, acidosis in, xx, 173
— blood chemistry in, xx, 138
— clinical symptoms of, xx, 136
— kidney function in, xx, 138
Acute gonorrheal arthritis, Still's disease differentiated from, vii, 105
Acute hemorrhage, blood-picture following, xi, 60
— course of, xi, 62
— physical signs of, xi, 61
— treatment of, xi, 62
Acute ileocolitis, course of lesions of, viii, 175
— description of, viii, 173
— diagnosis of, viii, 178
— etiology of, viii, 173
— lesions of, viii, 174
— prognosis of, viii, 179
— prophylaxis of, viii, 182
— symptoms of, viii, 176
— treatment of, viii, 180
Acute inanition, course of, x, 158
— etiology of, x, 156
— prognosis of, x, 158
— symptoms of, x, 157
— treatment of, x, 158
Acute infections, acute fasting with vomiting in, xiii, 24
— breast feeding prevented by, ii, 150
Acute infections, digestive symptoms and, xv, 1
Acute infectious arthritis, ankle manifestations encountered in, vi, 58
— clinical course of, vi, 51
— diagnosis of, vi, 52
— elbow and, vi, 67
— etiology of, vi, 50
— foot management in, vi, 58
— hand and, vi, 67
— hip-joint and, vi, 60
— joint tuberculosis differentiated from, vi, 71
— knee and, vi, 59
Acute infectious arthritis, laboratory and x-ray observations in, vi, 52
— pathology of, vi, 50
— physiotherapy and, vi, 57
— prognosis of, vi, 54
— psoas abscess and, vi, 60
— shoulder-joint and, vi, 66
— surgery and, vi, 53, 55
— symptoms of, vi, 51
— treatment of, vi, 54
— wrist and, vi, 67
Acute infectious diseases, blood-pictures in, xi, 47-52
Acute infectious mononucleosis, lymphatic leukemia differentiated from, xi, 141
Acute infectious osteomyelitis, diagnosis of, vi, 131
— etiology of, vi, 128
— local manifestations of, vi, 129
— pathology of, vi, 128
— prognosis of, vi, 133
— symptoms of, vi, 129
— treatment of, vi, 135
— x-ray and, vi, 130
Acute infectious spondylitis, diagnosis of, vi, 64
— prognosis of, vi, 64
— psoas abscess and, vi, 62
— symptoms of, vi, 62
— treatment of, vi, 66
— tuberculosis of spine differentiated from, vi, 91
— x-ray findings in, vi, 64
Acute infective synovitis and arthritis, pathology of, xv, 145
— treatment of, xv, 146
Acute inflammatory diarrhea, course of lesions of, viii, 175
— description of, viii, 173
— diagnosis of, viii, 178
— etiology of, viii, 173
— lesions of, viii, 174
— prognosis of, viii, 179
— prophylaxis of, viii, 182
— symptoms of, viii, 176
— treatment of, viii, 180
Acute inflammatory rheumatism, acute osteomyelitis differentiated from, xv, 135
— chronic tonsillitis and, ix, 60

Acute intestinal indigestion, character of stools in, xx, 73
— complications of, viii, 170
— course of, viii, 168
— diagnosis of, viii, 169
— etiology of, viii, 166
— prevention of, viii, 170
— symptoms of, viii, 168
— treatment of, viii, 170
Acute intestinal infection, frozen milk and symptoms of, xii, 19
Acute intestinal intoxication, indigestion and, xii, 125, 189
Acute intussusception, clinical features of, xv, 314
— differential diagnosis of, xv, 315
— etiology of, xv, 313
— onset of, xv, 3
— prognosis of, xv, 4
— sarcoma of intestine and, xv, 339
— treatment of, xv, 316
— varieties of, xv, 313
Acute laryngitis, character of cough of, ix, 99
— clinical types of, ix, 76
— obstruction caused by, ix, 83
— simple, diagnosis of, ix, 77
— — etiology of, ix, 76
— — symptoms of, ix, 76
— — treatment of, ix, 78
— spasmodic, diagnosis of, ix, 80
— — etiology of, ix, 79
— — symptoms of, ix, 79
— — treatment of, ix, 81
— traumatic, ix, 83
Acute luetic nephritis, blood chemistry in, xx, 147
Acute lymphadenitis, blood-count in, xi, 47
Acute lymphatic leukemia, blood-picture of, xi, 139; xx, 57
— case history of, xi, 133
— course of, xi, 141
— diagnosis of, xi, 140
— glandular fever differentiated from, xiv, 318
— physical signs of, xi, 138
— symptoms of, xi, 137
— treatment of, xi, 142
Acute meningitis, cerebrospinal fluid in, xx, 101
Acute miliary tuberculosis, typhoid fever differentiated from, xiv, 200
Acute mixed glomerulotubular nephritis, blood chemistry of, xx, 143
— clinical features of, xx, 143
Acute myelogenous leukemia, blood changes in, xx, 58
— blood-count of, xi, 152, 154
— case history of, xi, 150
— diagnosis of, xi, 155
— symptoms of, xi, 153
— treatment of, xi, 155
Acute nephritis, acidosis accompanying, xx, 173
— bacteriology of, xx, 145
— breast feeding prevented by, ii, 150
— prognosis of, xx, 146
— recognized groups of, xx, 135
— scurvy differentiated from, vii, 212
Acute non-infectious arthritis, vii, 86
Acute non-infectious synovitis, vii, 86
Acute orchitis, xv, 371
— symptoms and treatment of, xix, 216
Acute osteitis, rickets differentiated from, vii, 150
Acute osteomyelitis, acute rheumatic fever differentiated from, vii, 96
— age and sex incidence of, xv, 131
— anatomical considerations of, xv, 129
— clinical features of, xv, 133
— diagnosis of, xv, 135
— etiology of, xv, 130
— infants and, xv, 137
— pathology of, xv, 132
— postoperative care of, xv, 136
— prognosis of, xv, 136
— scurvy differentiated from, xiii, 125
— Still's disease differentiated from, vii, 105
— treatment of, xv, 135
Acute osteoperiostitis, acute osteomyelitis and, vii, 64
Acute pancreatitis, mumps causing, xiv, 147
Acute pericarditis, blood-count in, xi, 47

Acute peritonitis, newborn, iii, 207
Acute pharyngitis, diagnosis of, ix, 41
— etiology of, ix, 40
— symptoms of, ix, 40
— treatment of, ix, 41
Acute pleurisy, character of cough of, ix, 100
— diagnosis of, ix, 194
— etiology of, ix, 192
— pathology of, ix, 193
— physical signs of, ix, 194
— symptoms of, ix, 193
— treatment of, ix, 194
Acute pneumonia, ix, 137
Acute polioencephalitis, vomiting and, viii, 95
Acute purulent nephritis, xx, 13. *See* also Pyuria.
Acute purulent sialadenitis, iii, 197
— — sialo-adenitis, surgery of, xv, 188
Acute pyelitis, malaria differentiated from, xiv, 218
Acute pyelonephritis, pathology of, xix, 141
Acute pyuria, classification of, xx, 14
— urinary findings in, xx, 15
Acute retropharyngeal abscess, clinical features of, xv, 178
— treatment of, xv, 179
Acute rheumatic fever, arthritis of hereditary syphilis differentiated from, xvii, 247
— Aschoff's bodies in, xiv, 390; xviii, 19
— blood changes in, xi, 47, 49; xviii, 54
— blood-vessel pathology of, xviii, 37
— brain pathology and, xviii, 18
— chorea and, xviii, 18
— communicability of, xviii, 75
— complications of, vii, 95; xiv, 393
— convalescent care of, xviii, 58
— definition of, xiv, 388
— diagnosis of, vii, 95; xiv, 395
— epidemiology, xiv, 388
— etiology of, vii, 90; xiv, 388
— heart pathology of, xviii, 21
— hip-joint disease differentiated from, vii, 127
Acute rheumatic fever, joint pathology and, xviii, 18
— kidney pathology in, xviii, 40
— leukocyte counts in, xx, 44
— lung pathology of, xviii, 39
— pathogenesis of, xviii, 16
— pathology of, vii, 92; xiv, 389; xviii, 18
— pericarditis and, xviii, 124
— pleural effusion and, xviii, 128
— pleural involvement in, xviii, 39
— prognosis of, vii, 98; xiv, 396
— prophylaxis of, xiv, 396
— scope of the term, xviii, 51
— scurvy differentiated from, vii, 211
— Still's disease differentiated from, vii, 104
— subcutaneous nodules and pathology of, xviii, 19
— summary of pathology of, xviii, 40
— symptoms of, vii, 92; xiv, 390
— synonyms of, xiv, 388
— treatment of, vii, 97; xiv, 396; xviii, 55
Acute rheumatic polyarthritis, convalescent care of, xviii, 58
— symptoms and signs of, xviii, 52
— treatment of, xviii, 55
Acute rheumatism, synonyms of, xiv, 388
Acute rhinitis, complications of, ix, 6
— diagnosis of, ix, 6
— etiology of, ix, 2
— hereditary susceptibility to, ix, 4
— pathology of, ix, 4
— predisposing causes of, ix, 3
— prognosis of, ix, 6
— prophylaxis of, ix, 8
— symptoms of, ix, 5
— treatment of, ix, 6
Acute scurvy, vii, 208
— pathology of, x, 224
— treatment of, vii, 215
Acute sepsis, anemia due to, xx, 50
— leukocytosis in, xx, 48
Acute spasmodic bronchitis, ix, 109
Acute spinal paralysis, synonyms of, xiv, 224
Acute suppurative osteomyelitis, acute epiphysitis type of, vii, 69
— course of, vii, 69

Acute suppurative osteomyelitis, etiology of, vii, 64
— pathology of, vii, 65
— symptoms of, vii, 68
Acute synovitis, vii, 83
Acute syphilitic osteochondritis, symptoms of, vii, 141
Acute syphilitic osteoperiostitis, case histories of, vii, 147
Acute tenosynovitis, vii, 261
Acute tetanus, surgical treatment of, xv, 9
Acute thecitis, vii, 261
Acute torticollis, vii, 237
Acute toxic gastritis, symptoms and treatment of, viii, 106
Acute tracheitis, character of cough of, ix, 99
Acute traumatic arthritis, vii, 86
— pathology of, vi, 118
Acute traumatic spondylitis, treatment of, vi, 122
Acute traumatic synovitis, vii, 86
Acute tuberculosis, early, acute osteomyelitis differentiated from, vii, 70
Acute tuberculous cervical adenitis, xv, 194
Acute tuberculous peritonitis, xv, 303
Acute tubular (parenchymatous) nephritis, blood chemistry in, xx, 142
— clinical features of, xx, 139
Acute wasting paralysis, vii, 240
Adalin, tachycardia and, i, 33
Addison's disease, original report of, xi, 4
— symptoms of, xiii, 93
— treatment of, xiii, 94
Additions to diet in infancy, iv, 48
Adductor spasm, encephalitis showing, v, 101
Adenitis, acute cervical, surgery of, xv, 189
— acute epidemic infections, synonyms of, xiv, 314
— bronchial, character of cough of, ix, 100
— cervical, acute follicular tonsillitis causing, ix, 54
— — chronic tonsillitis and, ix, 60
Adenitis, scarlet fever complicated by, xiv, 20
— — treatment of, xiv, 29
— sialo-acute suppurative, xv, 188
— tuberculous cervical, xiv, 342; xv, 192
Adenoidectomy, abscess of lung following, ix, 172
— indications for, viii, 51
Adenoids, accessory nasal sinus disease and, ix, 36
— anatomy of, ix, 49
— cardiac disease and, iv, 126
— character of cough of, ix, 99
— complications of, ix, 71
— diagnosis of, ix, 72
— digestive system affected by, viii, 50
— enlarged non-tuberculous bronchial glands and, ix, 211
— etiology of, ix, 68
— facial characteristics of, ix, 70
— function of, ix, 50
— incidence of, ix, 67
— malnutrition and, iv, 158; x, 188
— newborn, iii, 79
— pathology of, ix, 69
— predisposition to rhinitis and, ix, 4
— prognosis of, ix, 72
— prophylaxis of, ix, 74
— removal of, indications for, viii, 51
— symptoms of, ix, 69
— tonsils and, preschool age, iv, 157, 158, 159
— treatment of, ix, 73
— tuberculosis of, xiv, 350
Adenoma sebaceum, diagnosis of, xvi, 25
— etiology of, xvi, 23
— pathology of, xvi, 23
— prognosis of, xvi, 25
— symptoms of, xvi, 22
— treatment of, xvi, 25
Adenomata, umbilical, xv, 282
Adenopathy, congenital syphilis and, iii, 47
Adherent prepuce, iii, 260
Adhesions, amniotic, deformities of upper extremities caused by, vii, 55
— — maldevelopment of face caused by, vii, 54

Adhesions, arachnoid, injury causing, v, 115
— arm-chest, treatment of, vi, 206
Adiadokocinesis, v, 12
Adolescence, blood-picture during, xi, 44
— importance of, iv, 67
— introspection during, iv, 67
— psychopathic traits and, iv, 121
— self-analysis during, iv, 67
Adolescent albuminuria, xx, 7
Adrenal glands, disease involving, Addison's disease, xiii, 93
— — chronic adrenal insufficiency, xiii, 93
— — hypernephromata, xiii, 94
— — hyperplasia of adrenols, xiii, 94
— — suprarenal cortex tumor, xiii, 95
— — symptoms of, xiii, 93
— — tumors, xiii, 94
— functions of, xiii, 92
— tuberculosis of, xiv, 355
— — relative frequency of, ix, 231
— tumors of, xiii, 94, 95; xv, 369
Adrenal hemorrhage, neonatal syphilis confused with, i, 63
Adrenal hyperplasia, xiii, 94
Adrenal insufficiency, chronic, symptoms of, xiii, 93
— — treatment of, xiii, 94
Adrenalin, accessory nasal sinus disease and, ix, 36
— activities of, xiii, 92
— acute bronchitis and, ix, 105
— alimentary hemorrhage and, iii, 186
— asthma and, ix, 115
— bronchopneumonia and, ix, 136
— epistaxis and, ix, 20
— nausea of pregnancy treated with, i, 26
— osteomalacia and, vii, 46
— pollen fevers and, ix, 119
— rhinitis and, iii, 78
— sepsis neonatorum and, iii, 17
— stimulant use of, respiratory diseases of, ix, 266
— traumatic rhinitis and, ix, 17
Adrenin, stimulant use of, respiratory diseases and, ix, 266
Adults, incidence of syphilis among, xvii, 86
Advice to mother, ii, 135
Agamanematodum migrans, xvi, 169
Age, caloric requirement and, xii, 67
— capacity of stomach and, xii, 64
— chemical composition of fetus and, ii, 46
— Chvostek's sign and, v, 134
— craniovertebral cavity and, v, 4
— death in relation to, iv, 105
— death rate of premature and, xii, 105
— diabetes mellitus and, xiii, 100
— diphtheria susceptibility and, iv, 133
— empyema prognosis and, xv, 231
— endurance of inanition and, x, 204
— enuresis and, xix, 50
— fetal, estimation of, ii, 160
— — length and weight and, ii, 161
— food requirements and, xii, 64
— growth—heredity and, xiii, 19
— head circumferences and, ii, 162
— heart rate and, ii, 55, 62
— heat production influenced by, ii, 97
— height—weight and, xiii, 6; x, 80-84
— incidence of deaths from heart disease and, xviii, 213
— incidence of neurosyphilis in relation to, xvii, 177
— lactating animals, chemical composition of milk and, xii, 10
— length as an aid to estimation of, ii, 161
— maternal, weight of newborn and, x, 45
— metabolism—temperature and, xiii, 5
— milk changes and, xii, 15
— parental, size of child influenced by, ii, 14
— possible variations in normal blood-counts according to, xi, 38
— preschool, growth during, iv, 19
— prognosis of hereditary syphilis influenced by, xvii, 251
— rheumatic heart disease and, xviii, 9
— rickets and, x, 230

Age, rigidity of craniovertebral cavity and, v, 5
— school, diet during, iv, 62
— serological results depending on, xx, 67
— specific gravity of urine and, xiii, 41
— tetany rare after two years, v, 134
— weight and height of infants and, iv, 17
— weight variations during pubescence, iv, 16
Age limits embracing "newborn," ii, 2
Agglutination, typhoid fever diagnosis by, viii, 191
Aglossia, iii, 130; viii, 5
Agnathia, iii, 131
Agranulocytic angina, blood changes in, xx, 57
Ague, fever and, synonyms of, xiv, 209
Air, fresh, for infants, i, 174
Air hunger, asthma and, ix, 115
Air injection, hydrocephalus and, v, 115
Air-swallowing, vomiting caused by, xii, 114
Airings, art of infant feeding and, xii, 145
Albee bone graft, scoliosis and, vi, 269
— spinal tuberculosis and, vi, 93, 94
Albinism, iii, 345, 359
Albinismus, xvi, 262, 288
Albinismus neonatorum, iii, 345
Albolene, acute rhinitis and, ix, 7
— newborn rhinitis and, iii, 78
— pollen fevers and, ix, 119
Albumin, cerebrospinal, normal, xx, 97
— serum and plasma, significance of, xx, 130
— urine and, ii, 107
Albumin milk, advantages of, ii, 158
— prematurity and, ii, 185
Albuminuria, i, 21
— cerebral palsies and, v, 142
— chickenpox complicated by, xiv, 74
— dietary measures for, xix, 62
— diphtheria causing, xiv, 166
Albuminuria, eclampsia and, ii, 108
— febrile, nephrosis and, xix, 78
— growth and, xix, 60
— incidence of, xix, 60
— maceration and, i, 49
— maternal death-rate due to, i, 4
— measles and, xiv, 46
— mumps causing, xiv, 147
— nephrosis and, xix, 78
— orthostatic, diagnosis of, xix, 61
— — incidence of, xix, 61
— — prognosis of, xix, 62
— — treatment of, xix, 62
— pyelitis cases and, i, 35
— scarlet fever complicated by, xiv, 20
— sepsis neonatorum causing, iii, 15
— significance of, xix, 59; xx, 3, 5
— toxemias and, i, 37, 38
— types of, xx, 6
— whooping-cough causing, xiv, 126
Alcohol, accidental poisoning with, viii, 311
— contractures and injection of, v, 145
— fetal abnormalities caused by, i, 67
— heart disease contraindicating, i, 32
— lobar pneumonia and, ix, 166
— puerperal infections contraindicating, i, 99
— use of, pregnancy and, i, 1, 24, 165
Alcoholism, mongolism and, xiii, 153
— prematurity caused by, ii, 163
— size of child affected by, ii, 14
Aleukemic leukemia, xi, 161
Aleukocytic leukemia, xi, 161
Alibour water, xvi, 349
Alimentary allergy, clinical manifestations of, viii, 318
— diagnosis of, viii, 319
— incidence of, viii, 316
— treatment of, viii, 320
Alimentary anemia, infancy and, viii, 102
Alimentary dextrose tolerance, comparison of children and adults with regard to, xx, 159
Alimentary glycosuria, diabetes mellitus differentiated from, xiii, 103

Alimentary tract, newborn, bacteria absent at birth, ii, 117
— — peculiarities of disease in, ii, 172
— — physiology of, ii, 82
— — prematurity and, ii, 167
— tumors of, iii, 193
Alkali reserve, carbohydrate deficiency depleting, x, 16
Alkalies, accidental poisoning with, viii, 310
— acidosis due to loss of, xx, 172
— acidosis treated by, x, 273
— therapeutic use of, respiratory diseases and, ix, 261
Alkaline diet, albuminuria and, xix, 63
Alkalinity of blood, decreased, ii, 171
Alkalinized milk, buffer action and, xii, 20
Alkalosis, etiology and symptoms of, x, 275
— gastric, loss of body chlorids causing, xiii, 36
— medication causing, xiii, 38
— respiratory, abnormal carbon dioxid secretion causing, xiii, 37
— symptomatology of, xx, 174
— tetany and, alkalosis due to medication, xiii, 38
— — gastric alkalosis due to loss of body chlorids, xiii, 36
— — infantile tetany, xiii, 37
— — parathyroid, xiii, 36
— — respiratory alkalosis due to abnormal excretion of carbon dioxid, xiii, 37
— — symptoms of, xiii, 33
— treatment of, xv, 26; xx, 174
Alkaptonuria, heredity and, iv, 8
— significance of, xx, 12
Allergic coryza, ix, 117
Allergic synovitis, vii, 88
Allergy, acute and chronic synovitis and arthritis and, vii, 83, 88
— alimentary, clinical manifestations of, viii, 318
— — diagnosis of, viii, 319
— — incidence of, viii, 316
— — treatment of, viii, 320
— asthma and, ix, 110
Allergy, convulsions and, v, 137
— eczema and, xvi, 117
— protein, clinical manifestations of, viii, 318
— — diagnosis of, viii, 319
— — incidence of, viii, 317
— — treatment of, viii, 320
— rheumatic fever and, xviii, 16
— tuberculosis diagnosis and, xiv, 336
— urticaria and, xvi, 74
Alopecia, syphilitic, incidence of, xvii, 124
Alopecia areata, congenital, iii, 350
— diagnosis of, xvi, 260
— etiology of, xvi, 259
— nail changes associated with, xvi, 269
— prognosis of, xvi, 261
— symptoms of, xvi, 257
— treatment of, xvi, 261, 350
Alopecia congenita, iii, 350
— etiology of, xvi, 252
— symptoms of, xvi, 252
— treatment of, xvi, 252
Alopecia symptomatica, xvi, 255
Alopecia totalis, xvi, 257
Alpine light, coxa plana and, vi, 110
Altitude, epistaxis and, ix, 19
— pollen fevers and, ix, 117
— tuberculosis and, ix, 221
Alveolar abscess, pyelitis of pregnancy and, i, 36
Alveolar tumors, xv, 181
Amaurotic familial idiocy, education impracticable for, v, 209
Amaurotic family idiocy, iii, 255
— general nature of, v, 219
— heredity and, v, 61
— ophthalmoscope proving, v, 17
Amebæ, staining methods for, xx, 77
Amebic dysentery, etiology of, viii, 305
— lesions of, viii, 306
— symptoms of, viii, 307
— treatment of, viii, 308
Amebiosis, pulmonary, ix, 186
Amelia, iii, 283
— definition of, vii, 57
American autumn fever, ix, 117
Amino-acids, breast and cow's milk content of, x, 12

Amino-acids, diet affecting quality of mixture of, ii, 142
— protein the source of, x, 12
Amino-acid nitrogen, ii, 78
— percentage in urine of newborn, ii, 105
Ammonia, urine containing, ii, 105
Ammonia nitrogen, ii, 78
Ammoniacal dermatitis, hereditary syphilitic lesions, differentiated from, xviii, 244
Ammoniated mercury, impetigo contagiosa and, iii, 327
Ammonium and ferric citrate, tonic use of, respiratory diseases and, ix, 267
Amnion, infection of fetus by way of, iii, 11
Amniotic cavity, infection of, i, 96
Amniotic hernia, xv, 257
Amniotic navel, iii, 400
Amniotic sac, asphyxia neonatorum and rupture of, ii, 191
Amylase, carbohydrate digestion by, x, 33
Amyloidosis, bilateral hematogenous renal disease and, xix, 101
Amylopsin, ii, 89
— carbohydrate digestion by, x, 33
Amyotonia congenita, iii, 248; v, 213
— progressive muscular atrophy and, v, 69
Amyotrophic lateral sclerosis, vii, 251
Anal condylomata, hereditary syphilis and, xvii, 247
Anal fissure, iii, 196
Anal reflex, ii, 113
Anaphylactic joints, Still's disease differentiated from, vii, 105
Anaphylactic shock, adrenalin for control of, ix, 266
Anaphylaxis, asthma and, ix, 109
— milk injections followed by, puerpal sepsis with, i, 103
— serum disease and, xiv, 292
Anatomy, developmental, x, 51
— — bones, x, 51
— — bladder, x, 68
— — brain, x, 71
— — cerebellum, x, 72
— — extremities, x, 60
Anatomy, developmental, heart, x, 70
— — intestines, x, 66
— — kidneys, x, 67
— — liver, x, 67
— — lungs, x, 71
— — mammary glands, x, 68
— — muscles, x, 63
— — skull, x, 52
— — spine, x, 58
— — spleen, x, 67
— — stomach, x, 65
— — teeth, x, 56
— — thorax, x, 62
— — thymus, x, 69
— — thyroid, x, 69
— — uterus, x, 68
— — viscera, x, 65
— mammary gland, ii, 139
— prematurity and peculiarities in, ii, 163
Ancient dislocations, vi, 177
Andree, syphilis described by, xvii, 7
Anemia, abortion causing, i, 6
— albuminuria resulting from, xx, 6
— alimentary, infancy and, viii, 102
— aplastic, blood changes in, xx, 49
— — case history of, xi, 88
— — first description of, xi, 5
— — idiopathic purpura hæmorrhagica differentiated from, xi, 198
— — physical signs of, xi, 91
— — symptoms of, xi, 90
— — treatment of, xi, 92
— blood parasites causing, xi, 77
— chemical poisons causing, xi, 80
— classification of, xx, 48
— diagnosis of hereditary syphilis and, xvii, 245
— erythroblastic, blood changes in, xx, 59
— familial hemolytic, blood changes in, xx, 59
— hemolytic, icterus index in, xx, 40
— — urobilin in, xx, 11
— hemorrhagic disease and, ii, 235
— hereditary hemolytic icterus causing, ii, 224
— idiopathic, Banti's disease, xi, 99
— — Gaucher's disease, xi, 113
— — hemolytic jaundice, xi, 116
— — Hodgkin's disease, xi, 120

Anemia, idiopathic, splenic anemia, xi, 101
— — von Jaksch's anemia, xi, 98
— infectious disease, xi, 69
— — course of, xi, 76
— — physical signs of, xi, 75
— — symptoms of, xi, 75
— — treatment of, xi, 77
— malnutrition course of, xi, 68
— — prognosis of, xi, 68
— — symptoms of, xi, 66
— — treatment of, xi, 68
— newborn, i, 112; iii, 120
— nursing and, iv, 48
— nutritional, blood changes due to, xx, 49
— pernicious, blood-picture of, xi, 100
— — breast feeding prevented by, ii, 150
— — diagnosis of, xi, 94
— — symptoms of, xi, 93
— — treatment of, xi, 95
— poisons causing, xi, 80
— prematurity and, ii, 172
— primary, aplastic anemia, xi, 87
— — blood changes in, xx, 49
— — chlorosis, xi, 85
— — pernicious anemia, xi, 93
— — sickle-cell anemia, xi, 95
— — *See also* Idiopathic anemias, xi, 98, 99, 101, 113, 116, 120
— primary splenic, treatment of, xv, 335
— rheumatic infections causing, xviii, 80
— secondary, accessory nasal sinus disease and, ix, 34
— — blood changes in, xi, 61; xx, 49
— — blood loss causing, xi, 59
— — bronchopneumonia and, ix, 129
— — chronic tonsillitis and, ix, 58
— — destruction a defective formation of blood causing, xi, 63
— — empyema and, ix, 204
— — epistaxis and, ix, 18
— — nephritis causing, xx, 50
— — nutritional diseases causing, xi, 63
— — scurvy causing, vii, 209
— sickle-cell, blood-picture of, xi, 96; xx, 49
Anemia, sickle-cell, etiology of, xi, 95
— — symptoms of, xi, 96
— — treatment of, xi, 97
— splenic, blood-picture of, xi, 100, 102, 106
— — course of, xi, 112
— — diagnosis of, xi, 111
— — original description of, xi, 4, 5
— — physical signs of, xi, 110
— — symptoms of, xi, 109
— — treatment of, xi, 112
— splenomegaly and, xx, 58
— syphilis and, xvii, 139
— transfusion and, xv, 51
— tumors causing, xi, 79
— von Jaksch's, blood-picture of, xi, 98; xx, 59
— — course of, xi, 112
— — diagnosis of, xi, 111
— — leukemia and, xi, 130
— — physical signs of, xi, 110
— — symptoms of, xi, 109
— — treatment of, xi, 112; xv, 335
Anemia pseudoleukemia infantum, blood changes in, xx, 59
Anencephalus, hereditary syphilis causing, i, 67
Anencephaly, iii, 213; vii, 53
Anesthesia, acidosis and, xiii, 25
— convulsions in, i, 38
— deaths from, acapnia and acidosis and, i, 130, 131
— ether, acute fasting with vomiting in, xiii, 25
— hyperglycemia following, xx, 163
— infections caused by, i, 91
— ketosis-acidosis associated with, xiii, 29
— — diet preventing, xiii, 31
— labor and, i, 109, 169
— lumbar puncture and, v, 88
— rectal, cardiac cases and, i, 33
— tuberculosis and, i, 29
Anesthetic, choice of, surgery of childhood and, xv, 29
— cyanosis caused by, ii, 205
Aneurysm, cirsoid, xv, 157
Anger, development period of, x, 73
— hyperglycemia and, xiii, 14
— malnutrition and, iv, 164

Angina, agranulocytic, blood changes in, xx, 57
— streptococcus, synonyms of, xiv, 308
— Vincent's, acute follicular tonsillitis differentiated from, ix, 53
— — diagnosis of, ix, 47
— — diphtheria complicated by, xiv, 167
— — diphtheria differentiated from, xiv, 168
— — etiology, viii, 41; ix, 46
— — pathogenic organisms of, xx, 92
— — symptoms of, viii, 41
— — treatment of, ix, 47
— — ulcerative stomatitis and, viii, 27
Angiokeratoma, diagnosis of, xvi, 297
— etiology of, xvi, 297
— pathology of, xvi, 297
— symptoms of, xvi, 297
— telangiectasia in, xvi, 295
— treatment of, xvi, 297
Angioma, arterial, xv, 157
— cavernous, xvi, 4
— lingual, viii, 4
— liver, iii, 201
— pulmonary, ix, 187
— skin, iii, 334
— tongue, iii, 193
— umbilical, iii, 409
Angioma serpiginosum, diagnosis of, xvi, 298
— etiology of, xvi, 298
— pathology of, xvi, 298
— prognosis of, xvi, 298
— symptoms of, xvi, 297
— telangiectasia in, xvi, 295
— treatment of, xvi, 298
Angioneurotic edema, diagnosis of, xvi, 77
— etiology of, xvi, 77
— hematuria and, xix, 69
— pathology of, xvi, 77
— prognosis of, xvi, 78
— symptoms of, xvi, 77
— synonyms of, xvi, 76
— treatment of, xvi, 78
Anhydremia, etiology of, x, 159
— lactic acid acidosis and, xx, 171
Anhydremia, marasmus and, x, 169
— symptoms of, x, 159
— treatment of, x, 160
Anhydremic intoxication, x, 159
Anidrosis, xvi, 276
Anilin oil, Winckel's disease and, iii, 2
Animals, asthma and, ix, 111, 116
Animal foods, chemical composition of, x, 286
Animal parasites, skin diseases caused by, general considerations of, xvi, 151
Animal protein, milk impairing gastric digestion of, xii, 130, 134
— salt and vitamins in, xii, 131, 133
Aniridia, iii, 357
Anisocytosis, definition of, xi, 15
Ankle, acute infectious arthritis of, vi, 58
— acute traumatic arthritis of, vi, 118
— braces for, vi, 28
— inspection of, vi, 12
— orthopedic examination of, vi, 12
— plaster-of-Paris supports for, vi, 27
— poliomyelitis affecting, orthopedic measures for, vi, 230
— puffiness of, pregnancy and, i, 162
— splinting of, vi, 27
— sprain of, vi, 118
— tuberculosis of, diagnosis of, vi, 76
— — treatment of, vi, 78
Ankle clonus, ii, 113
Ankle-joint tuberculosis of, diagnosis of, vii, 130
— — symptoms of, vii, 130
— — treatment of, vii, 131
Ankyloblepharon, iii, 359
Ankyloglossia, iii, 130
Ankylosis, acute infectious arthritis and, vi, 51, 54, 56
— congenital of jaw, iii, 131
— hip-joint, vi, 17
— Still's disease and, vii, 107
— treatment of, vii, 61
— tuberculosis and, vi, 70, 83
Ankylostoma duodenale, xvi, 171
— morphology and identification of, xx, 80
Annual pubescent growth, iv, 26, 27

Anodal closing contraction, tetany and, v, 132
Anodal opening contraction, tetany and, v, 133
Anomalies, bone, congenital and developmental, vii, 10
— cardiac, classification of, xviii, 130
— congenital, anomalies of spine, vi, 292
— — classification of, vi, 274
— — deformities of feet, vi, 280
— — deformities of hip, vi, 288
— — deformities of knee, vi, 287
— — ectopic testis, xix, 211
— — epispadias, xix, 214
— — etiology of, vi, 274
— — hydrocele, xix, 212
— — hypospadias, xix, 213
— — malnutrition and, iv, 152
— — narrowing of meatus, xix, 215
— — of nervous system, v, 50
— — obstruction of urethra, xix, 215
— — orthopedic management of, vi, 49, 273
— — paraphimosis, xix, 214
— — phimosis, xix, 214
— — torticollis, vi, 292
— kidney, embryological considerations of, xix, 8
Anopheles, characteristics of, xiv, 210
Anophthalmia, iii, 355
Anorexia, asthenia causing, viii, 220
— peculiarity of, newborn, ii, 172
Anoxemia, cyanosis and, ii, 204
— definition of, v, 24
— hemorrhagic disease and, ii, 232
Antenatal care, ii, 121
Antenatal death, abruptio placentæ and, i, 55, 56
— cardiac cases and, i, 33
— causes of, i, 9, 48, 117
— — convulsions, i, 39
— — cranial pressure, i, 117
— — falx and tentorium rupture, i, 117
— — labor complications, i, 111
— — maternal conditions, i, 9
— — syphilis, i, 63, 64
— induction of premature labor and, i, 107, 108
— in utero, i, 48-50
Antenatal death, midwives' responsibility for, i, 153
— placental separation and, i, 55
— prevention, prenatal care and, i, 8, 9, 10
— rates, i, 3, 4
— — syphilitic mothers treated during pregnancy and, i, 81, 82
Antenatal mortality, iv, 106
Antenatal syphilis, fetal deaths due to, i, 63
Antepartum hemorrhage, shock and, i, 130
Anterior horn cells, pathology of, v, 212
Anterior occipital presentation, molding following, ii, 25
Anterior poliomyelitis, acute, v, 102
— — acute syphilitic epiphysitis differentiated from, vii, 150
— — clinical course of, vi, 218
— — diagnosis of, vii, 243
— — etiology of, vi, 218; vii, 241
— — hip-joint dislocation following, vii, 60
— — infective nature of, v, 103
— — Little's disease differentiated from, vi, 239
— — onset of, vii, 240
— — operative measures for correction of deformity, vi, 228
— — orthopedic management of, vi, 218
— — pathology of, vi, 218; vii, 241
— — prognosis of, vi, 225
— — progressive muscular atrophy differeniated from, vi, 247
— — reflexes in, v, 104
— — scoliosis and, vi, 263
— — scurvy differentiated from, vii, 213
— — stages of, v, 104
— — symptoms of, v, 104; vi, 218; vii, 241
— — synonyms of, xiv, 224
— — treatment of, v, 105; vi, 226; vii, 244
— — Volkmann's paralysis differentiated from, vi, 212
— cause of, iv, 141
— cerebrospinal fluid in, xx, 115

Anterior poliomyelitis, leukocytosis in, xx, 44
— newborn and, iii, 31
— prevention of, iv, 141
— susceptibility to, iv, 128
Anterior spina bifida, clinical course of, xv, 212
— clinical features of, xv, 211
— differential diagnosis of, xv, 214
— treatment of, xv, 214, 215
Anthrax, milk transmission of, xii, 13; xx, 122
Anthropometric data of newborn, ii, 13
— weights and lengths at various fetal ages, ii, 161
— when secured, ii, 135
Antibodies, definition of, xiv, 4
Antigens, definition of, xiv, 5
— Wassermann reaction, xvii, 44
Antimeningococcic serum, cerebrospinal meningitis therapy and, xiv, 288
Antineuritic vitamin, beriberi and, x, 22
— source of, x, 23
Anti-ophthalmic vitamin, source of, x, 22
— value of, x, 22
Antipruritic salve, formula of, xvi, 348
Antipyretics, therapeutic use of, respiratory diseases and, ix, 261
Antipyrin, analgesic use of, respiratory diseases and, ix, 265
— antipyrectic use of, respiratory diseases and, ix, 261
— asthma and, ix, 115
— dermatitis caused by, xvi, 48
Antirachitic vitamin, iv, 122
— source of, x, 24
Antirachitic vitamin D, osteomalacia and, xiii, 167
— rickets and, xiii, 114, 117
Antiscorbutic food values, table of, xiii, 127
Antiscorbutic substance, vii, 207
Antiscorbutic vitamin, iv, 124
— infantile scurvy due to deficiency in, xvi, 71
— scurvy and, x, 23, 219, 227
Antiscorbutic vitamin, source of, x, 23
Antiseptics, therapeutic use of, respiratory diseases and, ix, 262
Antiseptic solutions, cerebrospinal injections of, v, 96
Antistreptococcus serum, scarlet fever treatment and, xiv, 31
Antitetanic serum, use of, xv, 11
Antithrombin, clotting and, ii, 232
Antitoxin, diphtheria, newborn and, iii, 23, 26
— — therapeutic use of, xiv, 170
— measles, xiv, 56
— qualifications for use of, xiv, 7
— scarlet fever, xiv, 30
— tetanus, xiv, 304
— — dose for newborn, iii, 33
Antitoxin rashes, measles differentiated from, xiv, 49
Anuria, erysipelas causing, iii, 19
Anus, atresia of, iii, 166
— congenital abnormalities of, viii, 287
— development of, xv, 341
— embryology of, viii, 287
— fissure of, viii, 293
— — clinical features of, xv, 345
— fistula in, xv, 348
— imperforate, viii, 287
— infection by way of, ii, 118
— infections from, labor and, i, 96
— malformations of, xv, 341
— perianal abscess, xv, 347
— prolapse of, viii, 289
— rhagades at, syphilitic infants and, i, 75
— tuberculosis ulcerosa about, xvi, 232
Anxiety, pregnancy and, i, 39, 169
— breast feeding and, i, 140
— hemorrhage and, i, 50
Aorta, anomalies of, iii, 111
— coarctation of, xviii, 145
— congenital stenosis and atresia of orifice of, iii, 108
— dextroversion of, iii, 108
Aortic disease, pregnancy and, i, 30, 31
Aortic insufficiency, diagnosis of, xviii, 195

Aortic insufficiency, pathological physiology of, xviii, 46
— physical signs of, xviii, 120
— x-ray signs of, xviii, 158
Aortic stenosis, diagnosis of, xviii, 198
— pathological physiology of, xviii, 46
— physical signs of, xviii, 122
Aortic valve, pathological physiology of, xviii, 46
Aortitis, rheumatic, pathology of, xviii, 37
Apes mellificæ, iii, 348
Aphakia, congenital, iii, 356
Aphasia, typhoid fever and, viii, 191
Aphonia, simple acute laryngitis causing, ix, 77
Aphthæ, Bednar's, iii, 188
Aplastic anemia, blood changes in, xx, 49
— case history of, xi, 88
— first description of, xi, 5
— idiopathic purpura hæmorrhagica differentiated from, xi, 198
— physical signs of, xi, 91
— symptoms of, xi, 90
— treatment of, xi, 92
Apnea, cervical cord injury causing, v, 35
Apophysitis, os calcis, diagnosis of, vii, 80
— — etiology of, vii, 79
— — pathology of, vii, 80
— — symptoms of, vii, 80
— — treatment of, vii, 80
— tibial tubercle, etiology of, vii, 77
— — symptoms of, vii, 78
— — treatment of, vii, 79
Apparatus, artificial respiration, ii, 200
— orthopedic, vi, 26
— — calot jacket, vi, 41
— — function restoration by, vi, 44
— — general considerations, vi, 26
— — head and neck, vi, 39
— — low-grade joint affections and, vi, 72
— — measurement of braces, vi, 46
— — Sayre suspension, vi, 39
— — symptoms of constriction, vi, 45
— — time element in use of, vi, 1
Apparatus, orthopedic, affections mistaken for, viii, 254
— — anatomy of, viii, 250
— — clinical features, xv, 306
— — diagnosis of, viii, 253
— — differential diagnosis of, xv, 307
— — etiology of, viii, 249
— — incidence of, xv, 305
— — lobar pneumonia, differentiated from, ix, 157, 159
— — pathology of, viii, 250
— — prognosis of, viii, 255
— — symptoms of, viii, 251
— — treatment of, viii, 255; xv, 308
— asthma and, ix, 112
— chronic, diagnosis of, xv, 310
— newborn, iii, 193
— subacute, diagnosis of, xv, 310
— tuberculous, xiv, 352
Appendix, anatomy at birth, viii, 250
Appetite, accessory nasal sinus disease and, ix, 29
— anger causing failure of, iv, 71
— deficient, viii, 220
— importance of, ii, 150; xii, 56, 92
— — interval between feedings and, xii, 138, 167
— perverted, viii, 220
— vitamin B and, x, 23
Apple juice, bottle feeding supplemented by, xii, 131
Apprehension, pregnancy and, i, 169
Aprosexia, adenoids causing, ix, 71
Apus, vii, 57
Aquisitiveness, development of, iv, 70
Arachnoid, v, 111
— reaction to injury, v, 115
Aran-Duchenne's atrophy, v, 69
Aran-Duchenne, progressive muscular atrophy of, vii, 251
Arantius, duct of, iii, 129
Arborization block, electrocardiographic determination of, xviii, 177
Arch, fallen, supports for, vi, 259
— — osteoporosis and, vi, 18
Argyria, hyperpigmentation and, xvi, 286
Argyrol, acute follicular tonsillitis and, ix, 56
— acute pharyngitis and, ix. 41

Argyrol, acute rhinitis and, ix, 7
— antiseptic use of, respiratory diseases and, ix, 262
— eyes treated with, i, 137, 169
— gonorrhea treated with, pregnancy and, i, 62
Arhythmia, pregnancy and, i, 31, 33
— sinus, diagnosis of, xviii, 199
— — electrocardiographic determination of, xviii, 170
Arm, fractures of, birth, i, 123
— newborn, proportions of, ii, 29
— palsy of, birth, treatment of, i, 124, 125
— paralysis of, iii, 226, 227
— — newborn, treatment of, i, 127
Arm-chest adhesions, treatment of, vi, 206
Arsenic, accidental poisoning with, viii, 311
— dermatitis caused by, xvi, 48, 52
— ulcerative stomatitis and, viii, 29
Arsenical poisoning, prematurity caused by, ii, 163
Arsenicals, treatment of syphilis with, xvii, 262
— — pregnancy and, i, 80, 81
Arsphenamin, bone and joint syphilis and, vi, 102
— congenital syphilis and, iii, 54; ix, 15
— dermatitis caused by, xvi, 48
— discovery of, xvii, 16
— exfoliative dermatitis following injections of, xvii, 274, 277
— hemorrhagic encephalitis followed by, xvii, 272
— Jarisch-Herxheimer reaction following, xvii, 279
— jaundice following injections of, xvii, 272, 275
— nitritoid crisis following injections of, xvii, 271
— reactions following injections of, xvii, 269
— skin reactions following injections of, xvii, 273
— syphilis of bones and joints and, vii, 151
— treatment of syphilis with, xvii, 262
Arsphenamin injections, syphilis treated with, pregnancy and, i, 80, 81, 82
— syphilitic infants and, i, 83
Art of infant feeding, xii, 143
— clothing, xii, 144
— education of parents, xii, 144
— exercise and rest, xii, 146
— sleep, xii, 147
— training, xii, 146
— ventilation, xii, 145
Arterial angiomata, xv, 157
Arteries, anomalies of, iii, 110
— coronary, pathology of rheumatic infection of, xviii, 38
Arteriosclerotic nephritis, blood chemistry in, xx, 153
— clinical features of, xx, 152
Arteritis, umbilical, iii, 406
Arthritic disease, subacute, course of, vii, 104
— — diagnosis of, vii, 104
— — etiology of, vii, 99
— — nomenclature of, vii, 98
— — pathology of, vii, 102
— — prognosis of, vii, 105, 107
— — signs and symptoms of, vii, 103
— — treatment of, vii, 106
Arthritic purpura, idiopathic, symptoms of, xi, 207, 208
Arthritis, accessory nasal sinus disease and, ix, 34
— acute, acute follicular tonsillitis causing, ix, 54
— acute gonorrheal, acute rheumatic fever differentiated from, vii, 97
— — Still's disease differentiated from, vii, 105
— acute infectious, ankle manifestations encountered in, vi, 58
— — clinical course of, vi, 51
— — diagnosis of, vi, 52
— — elbow and, vi, 67
— — etiology of, vi, 50
— — foot management in, vi, 58
— — hand and, vi, 67
— — hip-joint and, vi, 60
— — joint tuberculosis differentiated from, vi, 71
— — knee and, vi, 59

Arthritis, acute infectious, laboratory and x-ray observations in, vi, 52
— — pathology of, vi, 50
— — physiotherapy and, vi, 57
— — prognosis of, vi, 54
— — psoas abscess and, vi, 60
— — shoulder-joint and, vi, 66
— — surgery and, vi, 53, 55
— — symptoms of, vi, 51
— — treatment of, vi, 54
— — wrist and, vi, 67
— acute infective, pathology of, xv, 145
— — treatment of, xv, 146
— acute non-infectious, vii, 86
— acute rheumatic fever and, xiv, 391
— acute traumatic, vii, 86
— acute traumatic, pathology of, vi, 118
— asthma and, ix, 112
— cardiac disease and, iv, 126
— cerebrospinal meningitis and, xiv, 282, 291
— chickenpox causing, xiv, 75
— chronic infectious, clinical course of, vi, 103
— — diagnosis of, vi, 104
— — etiology of, vi, 102
— — pathology of, vi, 103
— — prognosis of, vi, 105
— — symptoms of, vi, 103
— — treatment of, vi, 105
— — types of, vi, 103
— — x-ray and, vi, 104
— chronic traumatic, character of, vi, 123
— congenital syphilis and, xvii, 247
— gonorrheal, iii, 308
— hemorrhagic, Still's disease differentiated from, vii, 105
— infancy and peculiarities, xv, 148
— infectious, acute osteomyelitis differentiated from, xv, 135
— lobar pneumonia causing, ix, 160
— progressive polyarticular, vi, 106
— rheumatoid, course of, vii, 104
— — diagnosis of, vii, 104
— — etiology of, vii, 99
— — nomenclature of, vii, 98
— — pathology of, vii, 102
Arthritis, rheumatoid, prognosis of, vii, 105, 107
— — signs and symptoms of, vii, 103
— — treatment of, vii, 106
— scarlet fever complicated by, xiv, 21
— serum, vii, 88
— subacute traumatic, characteristics of, vi, 123
— syphilitic, acute rheumatic fever differentiated from, vii, 96
— — incidence of, xvii, 149
— tonsillectomy and, ix, 60
— tuberculous, vi, 68
— — acute rheumatic fever differentiated from, vii, 96
Arthritis deformans, acute rheumatic fever differentiated from, vii, 96
— clinical course of, vi, 106
— treatment of, vi, 107
Arthritis deformans juvenilis, course of, vii, 104
— diagnosis of, vii, 104
— etiology of, vii, 99
— nomenclature of, vii, 98
— pathology of, vii, 102
— prognosis of, vii, 105, 107
— signs and symptoms of, vii, 103
— treatment of, vii, 106
Arthrodesis, age affecting justification of, vi, 1
— flat-foot and, vi, 260
— poliomyelitis affecting shoulder and, vi, 235
Arthroplasty, elbow dislocation and, vi, 178
Articular rheumatism, acute, acute osteomyelitis differentiated from, vii, 70
— — complications of, vii, 95
— — diagnosis of, vii, 95
— — etiology of, vii, 90
— — pathology of, vii, 92
— — prognosis of, vii, 98
— — scurvy differentiated from, xiii, 125
— — symptoms of, vii, 92
— — treatment of, vii, 97
Artificial dermatitis, classification of, xvi, 33

Artificial feeding, dextrin-maltose and, ii, 158
— indications for, ii, 157
— number of, ii, 158
— prematurity and, ii, 185
— preventive pediatrics and, iv, 51
— results obtained by, ii, 158
— tuberculosis necessitating, ii, 150
Artificial light, composition of, vii, 217
— pathogenic microörganisms and, vii, 218
— rickets treated by, vii, 200
— sunlight compared with, vii, 219
Artificial respiration, apparatus for, ii, 200
— asphyxia neonatorum and, ii, 198
Artificially fed infant, constipation in, viii, 223
— dyspepsia in, etiology of, viii, 161
— — physiological chemistry of, viii, 162
— — starch causing, viii, 164
— — symptoms of, viii, 162
— — treatment of, viii, 163
Ascariasis, pulmonary, ix, 186
Ascaris lumbricoides, benign jaundice from, viii, 328
— intestinal infestation with, viii, 299
— lungs affected by, ix, 186
— morphology and identification of, xx, 79
Aschoff bodies, acute rheumatic fever and, xiv, 390
— experimental streptococcic production of, xviii, 15
— joint tissues showing, xviii, 18
— prognosis of heart disease and, xviii, 210
— pulmonary rheumatism and, xviii, 39
— rheumatic aortitis and, xviii, 37
— rheumatic carditis and, xviii, 65
— rheumatic myocarditis and, xviii, 21
— rheumatic pericarditis and, xviii, 37
— structure of, xviii, 22
— subcutaneous rheumatic nodules and, xviii, 69
Ascites, fetal, umbilical hernia and, iii, 158
Ascites, newborn, causes of, iii, 205
— rheumatic infections and, xviii, 82, 89
— tuberculous peritonitis and, viii, 280; xv, 303
Asepsis, labor and, i, 86, 95, 109
— miscarriages and, i, 47, 109
— prematurity demanding, ii, 180
Ash, colostrum and, ii, 144
— fetal, composition at various ages, ii, 47
— — estimation of, ii, 46
— muscle, ii, 111
— newborn blood and, ii, 75
Asiatic cholera, dehydration and, xiii, 42
Asphyxia, acquired, ii, 201
— — symptoms of, ii, 194
— alimentary hemorrhage and, iii, 181
— congenital or intra-uterine, ii, 190, 193
— — symptoms of, ii, 193
— congenital acro-, ii, 196
— death from inanition and, x, 216
— definition of, v, 24
— extra-uterine or acquired, ii, 201
— hemorrhagic disease and, ii, 232
— intra-uterine, ii, 190
— — symptoms of, ii, 193
— mortality during first 14 days, ii, 5
— pituitrin producing, ii, 196
— recurrence of, ii, 194
Asphyxia livida, ii, 197
— symptoms of, ii, 193
Asphyxia neonatorum, i, 137, 170; ii, 189
— amniotic sac rupture and, ii, 191
— artificial respiration in, ii, 198
— Buhl's disease and, iii, 5
— caffein used in, ii, 201
— camphorated oil in, ii, 201
— cause of, ii, 190
— cerebral brain rupture and, i, 114
— drug therapy in, ii, 201
— extra-uterine, ii, 194
— insufflation of oxygen in, ii, 199
— massage in, ii, 201
— oxygen insufflation and, ii, 199
— pathology of, ii, 192
— petechial hemorrhages in, ii, 192
— strychnia in, ii, 201

Asphyxia neonatorum, symptoms of, ii, 193
— urea nitrogen increased in, ii, 76
Asphyxia pallida, ii, 198
— symptoms of, ii, 193
Aspidium, accidental poisoning with, viii, 312
Aspiration, acute infectious arthritis and, vi, 55, 58, 59
— empyema and, xv, 231
— orthopedic examination by, vi, 8
— pleurisy with effusion and, ix, 198
— tubercle bacillus entering via, ix, 216
Aspiration pneumonia, ii, 195; ix, 176
Aspirin, mastitis and, i, 147
Asthenia, anorexia caused by, viii, 220
— rheumatic infections causing, xviii, 81
Asthenic uremia, symptoms of, xix, 113
Asthma, accessory nasal sinus disease and, ix, 30, 34
— adenoids causing, ix, 71
— adrenalin for control of, ix, 266
— bronchial, ix, 109
— chronic bronchitis following, ix, 107
— chronic tonsillitis and, ix, 60
— complications of, ix, 113
— diagnosis of, ix, 113
— enlarged non-tuberculous bronchial glands and, ix, 207
— etiology of, ix, 109
— experimental production of, ix, 111
— foreign protein determination in, ix, 113
— heredity and, iv, 11
— hypertrophic rhinitis causing, ix, 12
— incidence of, ix, 109
— pathology of, ix, 111
— physical signs of, ix, 112
— prognosis of, ix, 115
— pulmonary tuberculosis differentiated from, xiv, 351
— sensitization tests in, ix, 113
— sputum in, characteristic appearance of, xx, 84
— symptomatic character of, ix, 110
— symptoms of, ix, 112
— thymic, iii, 75
Asthma, thymic, symptoms of, xiii, 88
— treatment of, ix, 115
— types of, ix, 110
Asthmatic breathing, ix, 94
Asthmatic bronchitis, acute, ix, 109
Astigmatism, malnutrition and, iv, 156
Astragalectomy, vi, 232
Astruc, syphilis described by, xvii, 7
Ataxia, Friedreich's, v, 70
— — orthopedic management of, vi, 250
— hereditary, orthopedic management of, vi, 250
— interpretation of, v, 151
— synergia of muscles absent in, v, 12
Atelectasis, asphyxia neonatorum and, ii, 195
— cyanosis caused by, ii, 165, 205
— deaths during first 14 days, ii, 5
— newborn and, ii, 172; iii, 87
— — diagnosis of, iii, 89
— — pathology of, iii, 88
— — treatment of, iii, 90
— prematurity and, ii, 165
— rickets and, xiii, 116
Atelectatic bronchiectasis, iii, 92
Atheroma, xvi, 282
Athetosis, encephalitis showing, v, 102
— lenticular degeneration and, v, 75
Athrepsia, anemia secondary to, xi, 64
— tuberculosis and, iii, 64
Athreptic infants, nutritional characteristics of, xii, 6
Atony, gastric, viii, 94
Atresia, anal, cause of, iii, 166
— aortic orifice and, iii, 108
— colonic, cause of, iii, 145
— — diagnosis of, iii, 149
— — pathology of, iii, 146
— — prognosis of, iii, 150
— — symptoms of, iii, 148
— — treatment of, iii, 151
— congenital bile-duct, jaundice and, xv, 330
— duodenal, diagnosis of, viii, 236
— — hypertrophic pyloric stenosis differentiated from, viii, 120
— — prognosis and treatment of, viii, 237

Atresia, esophageal, congenital, iii, 135; viii, 72
— "inosculating" esophageal, iii, 70
— pulmonary, iii, 107
— rectal, cause of, iii, 166
— small intestine, cause of, iii, 145
— — diagnosis of, iii, 149
— — pathology of, iii, 146
— — prognosis of, iii, 150
— — symptoms of, iii, 148
— — treatment of, iii, 151
Atrichia, universal congenital, iii, 350
Atrioventricular rhythm, electrocardiographic determination of, xviii, 173
Atrophia pilorum propria, types of, xvi, 253
Atrophic muscular dystrophy, simple hereditary, vii, 255
Atrophic rhinitis, chronic, late inherited syphilis and, xvii, 171
— diagnosis of, ix, 14
— symptoms of, ix, 14
— synonyms for, ix, 13
— treatment of, ix, 14
Atrophy, acute yellow, fetal death and, i, 48
— Aran-Duchenne's, v, 69
— bone, vi, 181
— Charcot-Marie-Tooth's, v, 69
— congenital, orthopedics and, vi, 274
— convolutional, convulsions and, v, 137
— infantile progressive muscular (Werdnig-Hoffmann type), vii, 252
— ischemic muscular, vii, 239
— muscular, heredity and, iv, 8
— — juvenile type of, vii, 256
— neural progressive muscular, v, 215
— — hereditary syphilis and, xvii, 250
— optic, heredity and, iv, 8
— — latent syphilis and, xvii, 226
— — neurosyphilis and, xvii, 196
— postparalytic, peripheral nerve injury causing, vii, 256
— progressive muscular, iii, 250
— — clinical course of, vi, 246
— — diagnosis of, vi, 247
— — etiology of, vi, 246
— — hand type, vii, 251
Atrophy, progressive muscular, muscular dystrophy differentiated from, vi, 247
— — pathology of, vi, 246
— — symptoms of, vi, 246
— — treatment of, vi, 247
— progressive neural muscular (Charcot-Marie-Tooth), vii, 252
— pseudohypertrophic muscular, v, 63
— Werdnig-Hoffmann's, v, 69
Atropin, accidental poisoning with, viii, 312
— acute rhinitis and, ix, 7
— bronchopneumonia and, ix, 136
— congenital pyloric stenosis and, iii, 144
— dermatitis caused by, xvi, 48
— enuresis and, xix, 58
— foreign bodies in respiratory tract and, ix, 191
— gastro-enterospasm of infancy and, viii, 128
— hypertrophic pyloric stenosis and, viii, 122
— poisoning after dilatation by, v, 17
— stimulant use of, respiratory diseases and, ix, 266
Attendants, nursery, ii, 138
Attitude of newborn, ii, 10
Audition, newborn deficient in, ii, 7
Aura, epileptic, v, 138
Auricle, cervical, surgery of, xv, 188
— fibrillation of, pregnancy and, i, 31
Auricular endocarditis, pathology of, xviii, 24
Auricular fibrillation, electrocardiographic determination of, xviii, 180
— signs of, xviii, 95
Auricular flutter, electrocardiographic determination of, xviii, 180
Auriculoventricular node, physiology of, xviii, 43
Auriculoventricular orifiecs, congenital atresia and stenosis of, iii, 109
Auscultation, chest examination by, ix, 91
— lobar pneumonia and, ix, 147
— orthopedic examination by, vi, 8

Auscultatory percussion, chest examination by, ix, 97
Auspitz's sign, psoriasis and, xvi, 124
Austin Flint murmur, xviii, 195
Auto-erotic movements, v, 59
Autogenous vaccines, chronic infectious arthritis and, vi, 105
Auto-infection, puerperal sepsis and, i, 87, 91
— vaginal, i, 87
Auto-intoxication, death from inanition and, x, 216
Automobile accidents, childhood mortality from, iv, 118
Autopsies, infant, 9
— puerperal infections originating at, i, 86
Autumn fever, American, ix, 117
Autumnal fever, synonyms of, xiv, 188
Average normal gain during school age, iv, 26
Average weight for height during infancy, iv, 19
Average weight for height during preschool age, iv, 20
Avoirdupois and metric weights, conversion table of, x, 292
Avulsion, scalp, xv, 154
Awkwardness, period of, x, 74
Ayrshire cows, milk from, xii, 13, 166

Babcock's milk analysis, convenience of, xii, 20
Babinski's sign, cerebral palsy and, v, 149
— significance of, v, 11
Bacilli, skin diseases due to, xvi, 224
Bacilluria, etiology of, xix, 205
— treatment of, xix, 206
Bacillus acidi lactici, meningitis caused by, xx, 106
Bacillus acidophilus, bacteriotherapy with, xx, 126
— buttermilk and, xii, 37
Bacillus bulgaricus, bacteriotherapy with, xx, 126
— buttermilk and, xii, 37
Bacillus coli, meningitis caused by, cerebrospinal fluid in, xx, 112
Bacillus diphtheriæ, significance of, xx, 91
Bacillus fœtidus, xvi, 276
Bacillus fusiformis, Vincent's angina and, xx, 92
Bacillus influenzæ, examination of sputum for, xx, 85
Bacillus pertussis, examination of sputum for, xx, 85
Bacillus proteus, meningitis caused by, xx, 106
Bacillus tuberculosis, cultural characteristics of, ix, 217
— examination of sputum for, xx, 85
— septicemia caused by, ix, 228
— staining of, ix, 218
— types of, ix, 217
Bacillus typhosus, meningitis caused by, xx, 106
Back, congenital malformations of, surgery of, xv, 206
— painful or weak, vii, 277
— surgery of, anterior spina bifida, xv, 211
— — meningocele and meningomyelocele, xv, 210
— — myelocele, xv, 211
— — spina bifida, xv, 206
— — spina bifida occulta, xv, 208
— — syringomyelocele, xv, 210
— tumors of, surgery of, xv, 206
Backache, pregnancy and, i, 46
Bacon, bottle feeding supplemented by, xii, 133
Bacteremia, gangrene and, i, 94
— newborn, iii, 12
— protein injections in, i, 103
— staphylococcus causing, blood transfusion in, i, 104
— streptococcus causing, i, 93
— — serum treatment in, i, 103
Bacteria, milk-borne, xii, 14, 24
— stomach and, viii, 91
— transitory fever and absorption of products of, ii, 209
— urine in pregnancy and, i, 21
— — pyelitis cases and, i, 35, 36
— virulence of, factors determining, xiv, 2
Bacterial endocarditis, subacute, diagnosis of, xviii, 190, 199

Bacterial endocarditis, subacute, etiology of, xviii, 186
— — prognosis of, xviii, 186, 190
— — rheumatic carditis differentiated from, xviii, 186
Bacterial infections, chronic, nutritional needs and, xii, 6
— milk transmission of, xii, 13
Bacteriology, newborn and, ii, 117
— puerperal infections and, i, 87
Bacteriophage, arthritis and, vi, 55
Bags, rubber, induction of labor with, i, 108, 109
Balanitis, xv, 352
— symptoms and treatment of, xix, 219
Balanoposthitis, symptoms and treatment of, xix, 219
Balantidium coli, infestation with, viii, 309
— morphology and identification of, xx, 79
Baldness, iii, 350
Ballooning degeneration, herpes zoster and, xvi, 92
Bandages, orthopedic, plaster-of-Paris, vi, 26
Bands, ii, 129
Banti's disease, blood changes in, xx, 60
— course of, xi, 112
— diagnosis of, xi, 111
— discovery of, xi, 5
— etiology of, xi, 99
— physical signs of, xi, 110
— symptoms of, xi, 109
— treatment of, xi, 112; xv, 335
Barium, x-ray examination and, xv, 7
Barley water, infant feeding and, i, 145
Barlow's disease, vii, 203
Basal ganglia, choreiform disturbances from injury of, v, 49
— disorders affecting, v, 218
— effects of circulatory impairment of, v, 143
— lenticular degeneration and, v, 71
— muscle tone altered in diseases of, v, 1
Basal (standard) metabolism, body surface and, xiii, 10
Basal (standard) metabolism, conditions required for determining, xiii, 3
— "cost of digestion," xiii, 3, 16
— definition of, xiii, 2
— fever and, xiii, 5
— food consumed in, xii, 57
— formula for newborn rate of, xiii, 7
— growth and, xiii, 6
— height and, xiii, 8
— muscular activity and, xiii, 4
— nephrosis and, xix, 81, 83
— sex and, xiii, 12
— weight and, xiii, 10
Basilar meningitis, chronic, cerebrospinal fluid in, xx, 112
Basket-weave adhesive bandage, vi, 120
Basophils, morphology of, xi, 16
Bath, mustard, counterirritant use of, respiratory diseases and, ix, 258
— newborn, time and temperature of, ii, 125
— skin, xvi, 347
— sponge, cold, therapeutic use of, respiratory diseases and, ix, 250
— tepid, therapeutic use of, respiratory diseases and, ix, 259
Bathing, baby's, i, 173, 174
— pregnancy and, i, 167
Bathroom, general considerations of, ii, 131
Bauerwetzel, synonyms of, xiv, 141
Baumès's law of paternal germ transmission of syphilis, xvii, 64
Bazin's disease, diagnosis of, xvi, 236
— erythema nodosum differentiated from, xvi, 64
— etiology of, xvi, 236
— pathology of, xvi, 236
— symptoms of, xvi, 235
— treatment of, xvi, 236
Beans, bottle feeding supplemented by, xii, 134
Bear walk exercise, illus., i, 20
— retrodisplacement and, i, 19
— uterine misplacements corrected by, i, 161
Beau's lines, xvi, 267

Beck abdominal binder, primary shock and, i, 131
Bed, baby's, i, 172, 173
— pads for, labor and, i, 170
— type preferred for newborn, ii, 130
Bedbugs, iii, 348; xvi, 157
Bednar's aphthæ, iii, 188
Bed-pans, Bradford frame and use of, vi, 38
Bed-sores, etiology of, xvi, 33
Bedtime stories, hygiene and, iv, 85
Bed-wetting, xix, 47. See also Enuresis.
Beef, contraindicated in diet of pregnancy, i, 23, 24
— scraped, bottle feeding supplemented by, xii, 133
Beef juice, bottle feeding supplemented by, xii, 132
Bees, iii, 348
Behaviorism, psychology of, iv, 68
Belladonna, acute rhinitis and, ix, 7
— bronchopneumonia and, ix, 136
— dermatitis caused by, xvi, 48
— foreign bodies in respiratory tract and, ix, 191
— stimulant use of, respiratory diseases and, ix, 266
Bellevue Hospital, N. Y., prenatal care in, i, 10
Bell's palsy, poliomyelitis differentiated from, xiv, 243
Bence-Jones protein, significance of, xx, 8
— test for, xx, 8
Benedict cot-chamber, xiii, 1, 2
— Roth's modification of, xiii, 2, 5
Benign bone tumors, Bloodgood's, vi, 196
— chondroma, vi, 193; xv, 127
— osteochondroma, vi, 192
— osteoma or exostosis, xv, 125
— types of, vii, 160
Benign cystic epitheliomata, multiple, xvi, 27
Benign jaundice, round-worms causing, viii, 328
Benzoin, accessory nasal sinus disease and, ix, 36
— acute laryngitis and, ix, 78
Benzoin, inhalation of vapors of, respiratory diseases and, ix, 270
— lobar pneumonia and, ix, 166
— nipples treated with, i, 143
Benzol, primary absolute polycythemia treated with, xi, 221
Beriberi, etiology of, x, 264; xiii, 133
— history of, x, 264
— infantile, x, 265
— pathology of, x, 265
— prophylaxis of, x, 266
— symptoms of, x, 265; xiii, 133
— treatment of, x, 266; xiii, 134
— vitamin B and, x, 23
Berries, chemical content of, x, 289
Berwind Maternity Clinic, N. &., prenatal care in, i, 10
Beta-oxybutyric acid, amount in blood, xx, 132
— significance of, xx, 10
Bethencourt, syphilis described by, xvii, 6
Bial's orcin test for pentose, xx, 9
Biceps reflex, ii, 113
Bifid tongue, viii, 5
Bifid unula, iii, 77, 134
Bilateral empyema, management of, xv, 235
Bilateral hematogenous renal disease, amyloidosis and, xix, 101
— chronic diffuse nephropathy and, xix, 125
— edema as a symptom of, xix, 75
— hemorrhagic nephritis and, xix, 101
— infantile nephropathy, xix, 129
— nephrosis and, xix, 78
— renal stasis, xix, 128
Bile, secretion of, ii, 88
Bile-ducts, absence of, viii, 325
— congenital atresia of, jaundice and, xv, 330
— diseases of, iii, 201
— surgical aspects of jaundice, xv, 330
Bile pigments, excreta showing, ii, 88
Bile salts, fat digestion by, x, 30
— newborn showing increase of, ii, 213
Biliary passages, diseases of, gallstones (cholelithiasis), viii, 328
Biliousness, hepatic insufficiency and, viii, 327

Bilirubin, newborn blood showing presence of, ii, 72, 214
— secretion of, ii, 88
— urine and, ii, 107
Bilirubinemia, Van den Bergh's test for, xx, 40
Biliverdin, secretion of, ii, 88
Bilocular heart, iii, 105
Binder, abdominal, ii, 124
— — cesarean section and, i, 32
— — primary shock and, i, 131
— vomiting caused by, xii, 114
Binet tests, v, 156
— Stanford revision of, iv, 78; v, 157
Biological substances, dermatitis caused by, xvi, 47
Birth, abruptio placentæ and, i, 56
— accidents at, i, 4, 7, 8, 9, 130-135
— acidosis at, i, 91, 130-133
— anesthesia during, i, 109, 169
— — convulsions in, i, 38
— — deaths with, acapnia and acidosis causing, i, 130, 131
— — infection caused by, i, 91
— — rectal, cardiac cases and, i, 33
— — tuberculosis and, i, 29
— aseptic preparations at, i, 86, 95, 109
— bacteriology at, ii, 117
— blood-pressure, during, shock and, i, 131
— bougie method at, i, 110
— breech delivery, i, 8, 56, 60, 111, 117, 118, 121, 123, 131, 136
— — technic of, i, 128
— capacity of stomach at, xii, 54
— care after, ii, 123
— certificates of, need for, i, 174
— convulsions at, i, 4, 10, 36, 48, 116
— — treatment of i, 38, 39
— dangers of, i, 150
— decompensation in, treatment of, i, 32, 33
— digestive equipment at, xii, 54
— dystocia in, i, 19, 41
— exhaustion at, breast milk and, i, 141
— female breast at, xii, 157
— forceps delivery, birth palsy in, i, 125
Birth, forceps delivery, cardiac cases and, i, 32, 33
— — clavicular fracture in, i, 121
— — conservatism in, i, 19
— — convulsions after, i, 116
— — falx and tentorium ruptured in, i, 117
— — feeble-mindedness and, i, 111, 112
— — hematoma and, i, 125
— — hemorrhages in, bulbar and medullary, i, 120, 122
— — lacerations and, i, 89
— — placenta prævia and, i, 60
— — skull injuries in, i, 116
— hemorrhage during, i, 91, 150
— — brain, newborn, i, 139
— — central nervous system, death at birth and, i, 118, 119, 120
— — cerebral, newborn, i, 111, 112, 113, 137, 150
— — cerebrospinal, breech deliveries and, i, 117
— — dural, birth injuries and, i, 113
— — induction and, premature labor, i, 107
— — intracranial at birth, i, 111, 120
— history of patient and, i, 17
— hospital delivery, i, 5, 90, 157, 158, 162
— — sepsis in, i, 5, 90
— inertia and, i, 91
— infections during, i, 9, 86, 105
— — abortion and, i, 6, 43, 47
— — bacteriology of, i, 87
— — blood transfusion and, i, 103, 104
— — Census reports of, i, 2
— — charts, illus., i, 100, 102
— — chemical treatment of, i, 104
— — eclampsia and, i, 92
— — endometritis and, i, 93
— — frequency of, i, 90
— — gonococcus causing, i, 61, 94
— — hygienic prevention of, i, 95, 96
— — leukocyte count in, i, 101
— — maternal deaths due to, i, 86
— — metritis and, i, 93
— — midwives' responsibility in, i, 153
— — miscarriage and, i, 47
— — mortality rates of, i, 90

Birth, infections during, operative treatment of, i, 91, 104
— — pathology of, i, 88
— — placental, i, 91, 94
— — predisposing causes of, i, 91
— — prenatal care and, i, 5, 12
— — protein therapy and, i, 103
— — serums in, i, 99-103
— — specific treatment of, i, 97
— — *Staphylococcus aureus* causing, i, 87
— — streptococcus causing, i, 87
— — symptomatology of, i, 93
— — thrombophlebitis and, i, 94
— — thrombosis and, i, 89
— — treatment of, i, 95-104
— injuries at, i, 111, 112
— — cephalic, i, 8, 112
— — clavicular, i, 121, 123, 127
— — extremities and, i, 121
— — infant death due to, i, 7, 8
— — intrapartum, i, 111-129
— — nerves and, i, 124
— — obstetrical management and, i, 8
— — spinal, i, 117
— instructions, i, 95, 169
— lacerations at, i, 45, 88, 91
— — repair of, i, 89, 97
— liver functions present at, ii, 88
— mania at, acute, i, 40
— midwife's service at, i, 151-154
— operative delivery of, i, 91, 104
— — death from sepsis in, i, 90, 91
— — dystocia and, i, 19
— — inertia necessitating, i, 91
— — infections following, i, 87, 90, 91, 104
— — injuries in, i, 111, 128
— — pelvic examination and, i, 19
— — shock prevention and, i, 19
— pains at, i, 109, 169
— — abruptio placentæ and, i, 54, 55
— — acute cystoma and, i, 42
— — breast feeding and, i, 140
— — fibromyomata and, i, 44
— — heart, i, 30, 31
— — lower back, i, 169
— — neuralgic, toxemias and, i, 37
— — premature imitation of, i, 109
— — prenatal care and, i, 45
— palsy caused by, i, 124, 125
Birth, pancreatic ferments present at, ii, 89
— pelvic measurements at, i, 18
— photophobia at, ii, 114
— placenta prævia and, i, 60
— premature, cardiac cases and, i, 33
— — Census reports of, i, 2
— — conservatism and, i, 19
— — death in utero prevented by, i, 49
— — early infant death caused by, i, 6, 7
— — fetal death due to, i, 9
— — hemorrhage and, newborn, i, 138
— — hereditary, calcium in, i, 23
— — induction of, i, 106-110
— — prenatal care preventing, i, 7, 12, 15, 44, 149, 150
— — syphilis causing, i, 79
— — toxemias of pregnancy causing, i, 7
— — uterine myomata and, i, 42
— prenatal care and, i, 12, 15, 149
— public health measures, protection of mother and child and, i, 150-175
— reflexes at, ii, 113
— rubber bags and, i, 108
— sepsis causing deaths at, i, 4
— shock following accidents of, i, 130-135
— — primary, i, 131
— — secondary, i, 133
— shoulder delivery, i, 121, 122, 123, 128
— — fractures in, i, 127
— — subluxation in, birth palsy due to, i, 124
— — technic of, i, 128
— statistics of, U. S., inadequacy of, prenatal care and, i, 2
— stillbirths at, autopsy of, i, 9
— — breech deliveries and, i, 117
— — causes of, i, 8
— — Census reports of, i, 8
— — cerebral hemorrhage and, i, 112
— — frequency of conception and, i, 6
— — history of patient and, i, 17
— — reduction of, prenatal care and, i, 10, 12, 81, 82, 84
— — spinal injuries and, i, 121

Birth, stillbirths at, syphilis and, i, 63, 64, 77, 79, 84
— — tears and, falx and tentorium, i, 117
— — traumatism and, i, 111
— supplies for, i, 170
— tamponage in, i, 110
— toxemia and, i, 131
— tuberculosis and, i, 29
— tumors at, i, 18, 41-44, 45
— U. S. registration area for, iv, 108
— uterine myomata and, i, 42
— version delivery, i, 120, 121, 131
— — abortion and, i, 43
— — Braxton-Hicks, placenta prævia and, i, 60
— — cardiac cases and, i, 33
— — collapse in, i, 131
— — conservatism and, i, 19
— — decompensation and, i, 32
— — internal podalic, placenta prævia and, i, 60
— — spinal injuries and, i, 120, 121
— — vertex delivery, i, 117, 121
— Wassermann reaction at, i, 76
— weight at, average, ii, 14, 16
— — gestation and, iv, 16
— — increase during first year, iv, 14
— — maximum and minimum, ii, 17
— — mortality and, ii, 6
— — normal limit of, ii, 17
— — race influencing, iv, 17
— — recovery of, ii, 40
— — seasonal variation and, ii, 14
— — sex influence upon, iv, 17
— — social influence on, ii, 17
— — weight loss and, ii, 37
Birth fractures, clavicle, xv, 74
— femur, xv, 74
— humerus, xv, 69
Birth injuries, anterior horn cells affected by, v, 213
— bones involved in, iii, 290
— cerebral hemorrhage following, late manifestations of, xii, 142
— cerebral palsies and, v, 142, 149
— cerebrospinal fluid and, xx, 117
— congenital fractures differentiated from, vi, 175
— convulsions caused by, v, 129
— ear affected by, iii, 369
Birth injuries, eye and, iii, 363
— fractures and epiphyseal separations, xv, 69
— gastric indigestion and, xii, 110
— hydrocephalus caused by, v, 113
— infant mortality and, iv, 111
— infection following, iii, 11
— intracerebral hemorrhage, v, 47
— intracranial, v, 42
— — prognosis of, v, 48
— kidney involved in, iii, 269
— Little's disease and, vi, 237
— mortality due to, ii, 3
— newborn, iii, 224
— nutritional requirements and, xii, 6
— paralysis from, vii, 247
— peripheral nerve injuries, v, 26
— scalp and, xv, 152
— spinal cord injuries, v, 34
— — case history, v, 37
— syphilis contributing to, v, 81
— tentorial tear with hemorrhage, v, 46
Birthmarks, xvi, 1
— maternal impressions and, xvi, 10
Birth paralysis, vi, 243
Bismuth, nausea of pregnancy and, i, 25
— nipples treated with, i, 143
— tamponage of uterus with, i, 56
— — abortion and, i, 29, 48
— — placenta prævia and, i, 59
— treatment of syphilis with, xvii, 266
— x-ray examination and, xv, 6
Biting the nails, xvi, 266
Black fever, synonyms of, xiv, 265
Black flies, iii, 348; xvi, 160
Blackhead, xvi, 279
Black tongue, diagnosis of, xvi, 341
— etiology of, xvi, 341
— prognosis of, xvi, 341
— symptoms of, xvi, 340
— treatment of, xvi, 341
Blackwater fever, hemoglobinuria in, xix, 68
Bladder, anatomical considerations of, xix, 17, 27
— development of, x, 68
— diseases of, bacilluria, xix, 205
— — cystitis, xix, 207
— — diverticulum, xix, 203

Bladder, diseases of, exstrophy, xix, 198
— — neuromuscular dysfunction, xix, 201
— — prolapse, xix, 205
— — stones, xix, 209
— — tumors, xix, 208
— diverticulum of, incidence of, xix, 203
— embryological considerations of, xix, 8
— exstrophy of, clinical features of, xv, 357
— — embryology of, xix, 8
— — treatment of, xv, 358; xix, 198
— inflammation of, diagnosis of, xix, 208
— — incidence of, xix, 207
— — symptoms of, xix, 207
— neuromuscular dysfunction of, incidence of, xix, 201
— — signs and symptoms of, xix, 201
— — treatment of, xix, 202
— peripheral disturbances of, enuresis associated with, xix, 48
— prolapse of, incidence of, xix, 205
— spina bifida and paralysis of, vii, 49
— stones in, xix, 209
— — chronic pyelitis and, xix, 159
— trabeculation of, enuresis and, xix, 49
— tumors of, symptoms of, xix, 208
— ulceration of, hematuria and, xix, 70
— urinary, anatomy of, iii, 258
— — anomalies and malformations ot, iii, 265
— — exstrophy of, iii, 266
— — physiologic capacity of, ii, 100
— — pregnancy and, i, 34
— — pyelitis and, i, 34, 35, 36
Blastema, metanephrogenic, embryology of, xix, 1
Blastomycosis, diagnosis of, xvi, 199
— etiology of, xvi, 198
— pathology of, xvi, 198
— prognosis of, xvi, 199
— symptoms of, xvi, 198
— treatment of, xvi, 199
Blattern, synonyms of, xiv, 80
Blaud's pills, tonic use of, respiratory diseases and, ix, 267
Bleaching remedies, xvi, 351
Bleb test, edema shown by, xix, 75
Bleeder's joint, xv, 149
Bleeding, i, 50-61
— abortion and, i, 47
— abruptio placentæ and, i, 52-56
— danger signal, i, 45, 169
— hysterectomy and, i, 42
— placenta prævia and, i, 58
— prenatal care and, i, 12, 45, 150
— puerperal infections and, i, 91
— uterine myomata and, i, 42
Bleeding time, ii, 66; xx, 37
— determination of, xi, 27
Blennorrhea, chronic, ix, 9
Blennorrhea umbilici, iii, 403
Blindness, cerebrospinal meningitis causing, xiv, 293
— congenital, iii, 356
— infant, prenatal care perventing, i, 17
— latent syphilis and, xvii, 226
— mumps causing, xiv, 149
— whooping-cough and, xiv, 125
Blood, abnormal forms of cells in, xi, 15
— acetone bodies in, xx, 132
— — amount of, xx, 132
— acrodynia and changes in, xiii, 135
— acute rheumatic fever and, xiv, 393; xviii, 54
— anemia associated with disturbances of spleen and lymph-nodes, xi, 98
— anemia due to destruction or defective formation of, xi, 63
— anemia due to loss of, xi, 59
— anemic changes in, xx, 48
— anticoagulant used for, xx, 128
— bicarbonate in, significance of, xx, 131
— bilirubin in, Van den Bergh test for, xx, 40
— bleeding time of, xi, 27; xx, 37
— blood-platelet count, xi, 28
— calcium in, amount of, xx, 131
— calcium of, asthma and, ix, 116
— capillary resistance to, xx, 38

Blood, cerebrospinal meningitis and, xiv, 278
— character of clot in, xx, 38
— chemistry of, conditions showing changes in, xx, 134
— — general considerations of, xx, 127
— — pregnancy and, i, 22
— — rickets and changes in, xx, 175
— — tetany and changes in, xx, 175
— chicken, lobar pneumonia and, ix, 167
— chickenpox and, xiv, 71
— chlorids in, amount of, xx, 131
— cholesterol in, amount of, xx, 132
— clinical pathology of, xx, 26
— clotting of, neonatal, i, 113, 120, 138
— coagulation of, original description of, xi, 2
— — platelets and, xi, 6
— coagulation time determination, xi, 28
— coagulation time of, xx, 36
— — calcium lactate and, ix, 73
— collection of, xvii, 43
— color index of, xx, 31, 33
— conditions in which stools contain, xx, 74
— creatinin in, xx, 130
— decreased alkalinity of, susceptibility in newborn and, iii, 7
— diseases of, iii, 119
— — acute lymphatic leukemia, xi, 133
— — acute myelogenous leukemia, xi, 150
— — anemias associated with disturbances of spleen and lymph-nodes, xi, 98
— — anemia due to blood destruction, defective formation, or both, xi, 63
— — chloroma, xi, 169
— — chronic lymphatic leukemia, xi, 143
— — chronic myelogenous leukemia, xi, 156
— — functional absolute polycythemia, xi, 216
— — hemophilia, xi, 182
Blood, diseases of, hemorrhagic disease of newborn, xi, 177
— — historical résumé of, xi, 1
— — idiopathic anemias, xi, 98
— — idiopathic non-thrombopenic purpura, xi, 205
— — idiopathic purpura hæmorrhagica, xi, 190
— — leukemias, xi, 129
— — leukemias without leukocytosis (aleukemic or aleukocytic), xi, 161
— — non-thrombopenic purpura, xi, 204
— — polycythemia, xi, 215
— — primary absolute polycythemia, xi, 218
— — primary anemias, xi, 85
— — purpura, xi, 189, 191
— — relative polycythemia, xi, 215
— — secondary anemias, xi, 59
— — secondary non-thrombopenic purpura, xi, 209
— — secondary (symptomatic) thrombopenic purpura, xi, 201
— — surgical aspects of, xv, 50
— — thrombopenic purpura, xi, 190
— dyscrasia of, xx, 51
— — orthopedic considerations of, vi, 125
— equilibrium between formation and destruction of, xi, 13
— erythema infectiosum and, xiv, 322
— examination of, bleeding time determination, xi, 27
— — blood-platelet count, xi, 28
— — coagulation time determination, xi, 28
— — fragility of red blood-cells, xi, 29
— — group determination for transfusion, xi, 30
— — hemoglobin determination, xi, 25
— — making of smear for, xi, 26
— — obtaining specimen for, xi, 24
— — oxidase stain, xi, 29
— — red cell-count, xi, 24
— — routine procedures, xi, 23
— — smear examination in, xi, 27
— — staining the smear for, xi, 26
— — vital staining, xi, 29

Blood, examination of, white cell-count, xi, 25
— fat in, amount of, xx, 132
— fetal, calcium and, i, 139
— formed elements of, erythrocytes, xi, 11
— — examination of, xi, 23
— — leukocytes, xi, 16
— — platelets, xi, 21
— glandular fever and, xiv, 316
— grouping of, xx, 42
— hematocrit reading of, xx, 31, 33
— hemoglobin in 100 c.c of, xx, 26
— hydrogen-ion concentration of, mechanism for normal maintenance of, xx, 167
— icterus index in, xx, 39
— idiopathic anemias, xi, 98
— infancy and pictures of, xi, 37, 39
— injections of, neonatal, citrate method of, hemophilia and, i, 139
— — intracranial pressure and, i, 115
— — intramuscular, facial paralysis and, i, 128
— laboratory examination of, xvii, 43
— lactic acid content of, xx, 172
— leukocyte counts in miscellaneous conditions, xx, 42
— lobar pneumonia and, ix, 145
— loss of, anemia due to, xx, 49
— malaria diagnosis and, xiv, 218
— measles and, xiv, 41
— mineral compounds in, xx, 131
— mineral constituents of, xiii, 17
— mongolism and sugar in, xiii, 158
— mumps and, xiv, 146, 149
— nephrosis causing changes in, xix, 83
— newborn, iii, 119
— — acidosis and, ii, 98
— — alkaline reserve deficiency in, ii, 98
— — amino-acid nitrogen content of, ii, 78
— — ammonia nitrogen content of, ii, 78
— — ash content of, ii, 75
— — bile pigments in, ii, 72
— — biologic properties of, ii, 72
— — bleeding time of, ii, 66
Blood, newborn, calcium content of, ii, 79
— — carbon dioxid content of, ii, 78
— — cellular elements in newborn, ii, 67
— — chemistry of, ii, 73
— — cholestrin content of, ii, 79
— — coagulation of, scheme of, ii, 232
— — coagulation time of, ii, 65
— — color index of, ii, 65
— — creatin and creatinin content of, ii, 78
— — epinephrin content of, ii, 79
— — erythrocytes of, ii, 67
— — fat content of, ii, 79
— — hemoglobin percentage, ii, 64
— — hemorrhagic disease and, ii, 240
— — hydrogen ion concentration affected by prematurity, ii, 166
— — inanition fever from decrease of water content of, ii, 76
— — iso-agglutinins in, ii, 73
— — isohemolysins in, ii, 73
— — leukocytes of, ii, 68
— — leukocytosis during infarct period, ii, 105
— — mammary gland supply of, ii, 140
— — nitrogen content of, ii, 76
— — number of red blood-corpuscles in, xx, 28
— — number of white blood-corpuscles in, xx, 34
— — phosphorus compounds in, ii, 79
— — physiology of, ii, 63
— — prematurity and, ii, 167
— — protein content of, ii, 75
— — pseudo-globulin in, ii, 90
— — reactions of, ii, 74
— — refractive index of serum of, ii, 65
— — sodium content of, ii, 80
— — solids of, ii, 74
— — specific gravity of, ii, 65
— — sugar content in newborn, ii, 78
— — uric acid content of, ii, 77
— — viscosity of, ii, 65
— — water content of, ii, 75
— — weight-loss due to depletion of water content of, ii, 38

Blood, nitrogenous compounds in, xx, 129
— non-protein nitrogen in, xx, 129
— occult, stool and urine tested for, viii, 343
— oxidase stain of, xx, 41
— parasites in, anemia caused by, xi, 77
— phosphorus in, amount of, xx, 131
— platelets in, xx, 35
— poliomyelitis and, xiv, 241
— primary anemias of, xi, 85
— — aplastic anemia, xi, 87
— — chlorosis, xi, 85
— — pernicious anemia, xi, 93
— — sickle-cell anemia, xi, 95
— — *See also* Idiopathic anemia.
— prothrombin time of, xx, 37
— retroplacental, Wassermann reaction of, i, 76
— rickets and changes in, xx, 175
— rickets and chemistry of, vii, 189
— routine examination of, materials needed for, xi, 23
— saturation index of, xx, 32, 33
— scarlet fever and, xiv, 16, 22
— scurvy and changes in, xiii, 121
— sedimentation time of, xx, 37
— sepsis neonatorum causing changes in, iii, 15
— serological examination of, importance of, xx, 67
— — interpretation of, xx, 69
— — relation to treatment, xx, 70
— — reliability of, xx, 68
— serum and plasma proteins in, xx, 130
— special staining reactions of, xx, 41
— staining of, i, 15, 47, 50, 58, 169
— syphilis of, pathology of, xvii, 43
— tetany and calcium content of, v, 130
— tetany and changes in, xx, 175
— tetany and chemical constituents of, v, 135
— thrombogen time of, xx, 37
— time for taking specimen of, xx, 128
— transfusion of, abruptio placentæ and, i, 56
— — puerperal sepsis and, i, 103
Blood, transfusion of, shock following labor and, i, 134, 135
— tuberculosis and, ix, 230
— typhoid fever and, viii, 189
— ultraviolet rays and, x, 26
— urea in, xx, 130
— uric acid in, significance of, xx, 130
— vital staining of, xx, 42
— volume index of, xx, 32, 33
— volume of, xx, 30
— Wassermann reaction on, xvii, 44
— white blood-corpuscles in, xx, 42
— whooping-cough and, xiv, 126
— Winckel's disease and changes in, iii, 3
Blood-building organs, diseases of, acute lymphatic leukemia, xi, 133
— — acute myelogenous leukemia, xi, 150
— — anemias associated with disturbances of spleen and lymph-nodes, xi, 98
— — anemia due to blood destruction, defective formation, or both, xi, 63
— — chloroma, xi, 169
— — chronic lymphatic leukemia, xi, 143
— — chronic myelogenous leukemia, xi, 156
— — functional absolute polycythemia, xi, 216
— — hemophilia, xi, 182
— — hemorrhagic disease of newborn, xi, 177
— — historical résumé of, xi, 1
— — idiopathic anemias, xi, 98
— — idiopathic non-thrombopenic purpura, xi, 205
— — idiopathic purpura hæmorrhagica, xi, 190
— — leukemias, xi, 129
— — leukemais without leukocytosis (aleukemic or aleukocytic), xi, 161
— — non-thrombopenic purpura, xi, 204
— — polycythemia, xi, 215

Blood-building organs, diseases of, primary absolute polycythemia, xi, 218
— — primary anemias, xi, 85
— — purpura, xi, 189, 191
— — relative polycythemia, xi, 215
— — secondary anemia, xi, 59
— — secondary non-thrombopenic purpura, xi, 209
— — secondary (symptomatic) thrombopenic purpura, xi, 201
— — thrombopenic purpura, xi, 190
Blood chemistry, kidney function and, xx, 20
Blood-counts, normal adolescence, xi, 44
— normal childhood, xi, 43
— normal infant and child, possible variations in, xi, 38, 43
— normal newborn infant, xi, 39
Bloodgood's benign giant-celled bone tumor, vi, 196
Blood-grouping, xx, 42
Blood-pictures, acute infectious diseases and, xi, 47, 50, 52
— acute lymphatic leukemia, xi, 134, 139, 144
— acute myelogenous leukemia, xi, 144, 152, 154
— aleukemic leukemia, xi, 165
— anemia secondary to malnutrition, xi, 67
— aplastic anemia, xi, 89, 91
— chemical poisons and, xi, 54, 81
— chloroma, xi, 171
— chloroma of lymphatic type, xi, 144
— chlorosis, xi, 86, 100
— chronic blood loss in infancy, xi, 62
— chronic infectious diseases and, xi, 53
— chronic lymphatic leukemia, xi, 147
— chronic myelogenous leukemia, xi, 144, 158
— functional absolute polycythemia, xi, 217
— Gaucher's disease, xi, 114
— hemolytic jaundice, xi, 118
— hemophilia, xi, 184, 185
— hemorrhagic disease of newborn, xi, 179, 180
— Hodgkin's disease, xi, 124
Blood-pictures, idiopathic purpura hæmorrhagica, xi, 197
— infectious diseases, xi, 70, 76
— lymphatic leukemia, xi, 100
— malaria, xi, 78
— malignant tumors and, xi, 54
— nephrosis, xi, 74
— nutritional diseases, xi, 54, 64
— pernicious anemia, xi, 94, 100
— poisons, xi, 80
— primary absolute polycythemia, xi, 220
— secondary anemia due to blood loss, xi, 60
— sickle-cell anemia, xi, 96, 111
— splenic anemia, xi, 100, 111
— syphilitic secondary anemia, xi, 71
— thrombopenic purpura, xi, 197
— tuberculous secondary anemia, xi, 70
— tumors, xi, 79
— von Jaksch's anemia, xi, 98, 111
Blood-plasma, functions of, xi, 7
Blood-platelets, functions of, xi, 6
— hemorrhagic disease and, ii, 233
— morphology, origin and significance of, xi, 21
— number of, xx, 35
— purpura hæmorrhagica and, xi, 5
Blood-pressure, i, 18, 22, 160
— chronic high, fetal deaths and, i, 48
— decompensation and, pregnancy and, i, 32
— delivery and, i, 6, 131
— diffuse glomerulonephritis and, xix, 109
— newborn, ii, 56
— nitrogen partition examination and, i, 22
— normal according to age, table of, ix, 163
— — prematurity and, ii, 166
— shock following labor and, i, 131
— study of, xviii, 104
— systolic and diastolic, average measurements of, xviii, 104
— tests for, pregnancy and, i, 162
— toxemias of pregnancy and, i, 37
Blood-serum, alimentary hemorrhage and, iii, 185

Blood-sugar, celiac disease and, xx, 161
— inanition and reduced content of, xiii, 25
— infection and, xx, 161
— marasmus and, xx, 161
— nursing and, xii, 182
— tolerance tests for, xx, 159
— tuberculous meningitis and, xx, 163
— vomiting and, xx, 162
Blood-sugar determinations, conditions necessitating, xx, 158
Blood-vessels, rheumatic infection of, pathology of, xviii, 37
— syphilis of, pathology of, xvii, 37
Blue ointment, syphilitic infants treated with, i, 83
Blue spot, Mongolian, iii, 345
Blueness, neonatal, i, 137, 138
Body habitus, heredity and, iv, 12, 15
— malnutrition and, iv, 161
— postural defects and, iv, 35
Body heat, prematurity and maintenance of, ii, 177
Body-lice, xvi, 156
Body measurements, ii, 18
— daily increase before and after birth, ii, 42
Body proportions, ii, 21
— age and, iv, 30
— significance of deviation from normal in, ii, 30
Body surface, area of, ii, 110
— DuBois' linear formula, xiii, 11
— metabolism and, xiii, 10
— weight, metabolism and, xiii, 11
Body temperature, ii, 48
Body weight, metabolism and, ii, 97
— relation to intake and output, ii, 38
Bohn's epithelial pearls, viii, 1
Boiled milk, objections to use of, xii, 17, 19
Boils, etiology of, xvi, 217
— pathology of, xvi, 217
— smallpox and, xiv, 93
— symptoms of, xvi, 217
— treatment of, xvi, 218
Bolting of food, xii, 139, 154
Bones, acute affections of, osteomyelitis, vi, 128
Bones, adult and infant, special differences between, vii, 6
— affections of, orthopedic, vi, 48
— anatomy of, iii, 278; xv, 118
— anomalies of formation of, vii, 10
— — achondroplasia, vii, 11
— — chondrodystrophy fœtalis, vii, 11
— — dyschondroplasia, vii, 29
— — fetal chondrodystrophy, vii, 11
— — fetal rickets, vii, 11
— — general etiology of, vii, 10
— — multiple cartilaginous exostoses, vii, 20
— — multiple enchondromata, vii, 27
— atrophy of, vi, 181
— benign tumors of, xv, 125
— birth injuries to, iii, 290
— blood supply of, vii, 1; xv, 129
— brittleness of, vi, 190
— changes shown by x-ray of, vi, 10
— character of early, vi, 1
— characteristics of, ii, 48
— childhood peculiarities of, vii, 1, 6
— congenital and developmental anomalies of, vii, 10
— — achondroplasia, vii, 11
— — chondrodystrophy fœtalis, vii, 11
— — dyschondroplasia, vii, 29
— — fetal chondrodystrophy, vii, 11
— — fetal rickets, vii, 11
— — fragilitas ossium, vii, 29
— — multiple cartilaginous exostoses, vii, 20
— — multiple enchondromata, vii, 27
— — osteogenesis imperfecta, vii, 29
— — osteomalacia, vii, 45
— — osteopsathyrosis, vii, 29
— congenital defects and deformities of, vii, 47
— congenital deficiencies in quality of, vi, 189
— congenital syphilis and changes in, iii, 44
— cranial injuries to, i, 133
— cyst of, vi, 142; vii, 161
— development of, vii, 10; x, 51
— developmental diseases of, achondroplasia, xv, 119
— — cretinism or congenital myxedema, xv, 120
— — dyschondroplasia, xv, 121

Bones, developmental diseases of, multiple cartilaginous exostoses, xv, 121
— — myositis ossificans traumatica, xv, 124
— — osteitis fibrosa cystica, xv, 122
— diseases of, Brodie's abscess, xv, 139
— — general considerations of, xv, 118
— — heliotherapy and actinotherapy in, vii, 217, 221
— — Osgood-Schlatter's disease, xv, 141
— — osteomyelitis, xv, 129, 139
— — tuberculosis, xv, 140
— — tumors, xv, 125
— diseases of membranous formation of, fragilitas ossium, vii, 29
— — osteogenesis imperfecta, vii, 29
— — osteomalacia, vii, 45
— — osteopsathyrosis, vii, 29
— edema stimulating syphilis in, i, 63
— endocrine disturbances of, vi, 192
— fractures of, i, 128
— — leukocytosis following, xx, 48
— growth of, factors in, vii, 4
— — stimuli to, vii, 5
— gummata of, late inherited syphilis and, xvii, 157
— hereditary deficiency of, vi, 190
— infections of, iii, 308
— inflammations of, acute osteomyelitis, vii, 64
— — acute osteoperiostitis, vii, 64
— — epiphyseal injuries due to trauma or, vii, 73
— injuries to, fractures resulting from, vii, 154
— — peculiarities of, vii, 153
— — rickets predisposing to, vii, 153
— low-grade affections of, epiphysitis of extra-articular epiphyses, vi, 144
— — Garré's sclerosing osteomyelitis, vi, 139
— — osteitis fibrosa cystica, vi, 142
— — syphilis, vi, 136
— — tuberculosis, vi, 136
— malformations of, iii, 279
— malignant tumors of, xv, 127
Bones, marble, vi, 191
— neoplasms of, vi, 192, 200
— newborn, character of, vii, 153
— — morbid anatomy of, vii, 154
— nutritional disorders of, osteomalacia, vi, 187
— — rickets, vi, 182, 187
— — scurvy, vi, 188
— ossification centers of, prematurity and, ii, 164
— ossification process in development of, vii, 2
— osteochondritis of, i, 70-73
— peculiarities in childhood, vii, 1
— rachitic changes in, x, 238
— rachitic, general characteristics of, vii, 176
— scurvy and changes in, xiii, 121
— scurvy affecting, vii, 208, 210
— scurvy causing changes in, x, 221
— stigmata of, latent syphilis and, xvii, 227
— stimuli to growth of, vii, 5
— syphilis of, destructive stage of, vi, 138
— — diagnosis of, vi, 139
— — diagnosis of, vii, 145
— — differential diagnosis of, vii, 149
— — early congenital lesions of, vii, 136
— — Garré's sclerosing osteomyelitis and, vi, 139
— — joint involvement in, vii, 148
— — late lesions of, vii, 146
— — late manifestations of, xvii, 153
— — nature of, vii, 135
— — osteochondritis form of, vi, 137
— — osteomyelitis form of, vi, 138
— — pathological evidence of, xvii, 26, 34
— — periosteal stage of, vi, 137
— — prognosis of, vi, 139
— — symptoms of, vi, 136
— — treatment of, vi, 139; vii, 151
— — Wassermann test and, vi, 101
— syphilitic lesions of, i, 63, 70-73, 76
— — incidence of, xvii, 131
— transition of bony tissue, vii, 1
— traumatic affections of, vi, 147
— — dislocations, vi, 177

Bones, traumatic affections of, epiphyseal separations, vi, 166
— — fractures, vi, 147
— — malunited fractures, vi, 169
— — osteitis, vi, 181
— — osteoporosis, vi, 181
— — ununited fractures, vi, 174
— tuberculosis of, vi, 136; xiv, 356
— — bone marrow changes in, vii, 114
— — diagnosis of, vii, 115
— — differential diagnosis of, vii, 116
— — general considerations of, vii, 108
— — incidence of human and bovine, vii, 109
— — manifestations of, xv, 140
— — mode of infection in, vii, 111
— — occurrence of, vii, 112
— — pathology of, vii, 113
— — predisposing causes of, vii, 110
— — prognosis of, vii, 117
— — regional frequency of, vii, 113
— — scurvy differentiated from, vii, 212
— — special areas affected by, vii, 118
— — symptoms of, vii, 114
— — treatment of, vii, 117
— — types of organism causing, vii, 108
— tumors of, iii, 309; vi, 192, 200
— — benign, vii, 160
— — frequency of, vii, 160
— — malignant, vii, 161
— vascular supply of, vii, 1
— x-ray examination of, vi, 9
Bone abscess, clinical signs of, vii, 71
— complications of, vii, 71
— sequelæ of, vii, 73
— treatment of, vii, 72
— x-ray diagnosis of, vii, 72
Bone-grafts, age of child and, vi, 176
— congenital fractures and, vi, 176
— massive, ununited fractures and, vi, 174
Bone-marrow, acute myelogenous leukemia and, xi, 150
— composition of, vii, 5
— — postnatal changes in, vii, 5
— hematopoietic function of, xi, 12
— method of transfer of blood cells to circulation from, xi, 13
Bone-marrow, tuberculosis causing changes in, vii, 114
Boracic acid, nipples treated with, i, 143
— urine analysis and, i, 21
Borax, diapers with, care of, i, 172
Borchard's Malt Soup Extract, xii, 41, 43
Bordet, work on syphilis by, xvii, 15
Bordet-Gengou bacillus, pertussis caused by, iv, 140
— whooping-cough and, xiv, 118, 127
Boric acid, atrophic rhinitis and, ix, 14
Boric acid ointment, formula of, xvi, 347
Botalli, duct of, ii, 53
Bothriocephalus latus, intestinal infestation with, viii, 304
— morphology and identification of, xx, 82
Botriomycosis hominis, xvi, 220
Bottle bacillus of Malassez, xvi, 136
Bottle feeding, i, 140, 141
— additions to, xii, 129-135
— — beef juice, xii, 132
— — broths, xii, 132
— — cereals, xii, 131
— — eggs, xii, 133
— — fruit juices, xii, 131
— — meats, xii, 133
— — time to make, xii, 129
— — types of food, xii, 130
— — vegetables, xii, 134
— — water between meals, xii, 130
Bottom milk, composition of, xii, 25
Botulism, etiology of, viii, 315
— symptoms of, viii, 316
— treatment of, viii, 316
Bougie, labor induction with, i, 110
Bouillon, Delbet's, erysipelas and, iii, 20
Bovine tuberculosis, distribution of, iv, 144
Bowels, infants', regulation of habit in, i, 174
Bowel regulation, hygiene and, iv, 89
— infancy and, iv, 89
Bow-leg, pathology of, vi, 183
— rickets causing, vi, 182
— treatment of, vi, 185

Bowman's capsule, development of, xix, 2
Brace, orthopedic, Bradford's abduction, vi, 110, 113
— — knee, vi, 33
— — measurement of, vi, 46
— — plaster-of-Paris, vi, 28
— — poliomyelitis and, vi, 235
— — spiral, vi, 42
Brachial paralysis, cause of, v, 26
— deformity following, v, 26
— laissez-faire "treatment" condemned, v, 33
— treatment of, v, 27
Brachial plexus, avulsion of, v, 35
Brachial plexus birth paralysis, vii, 256
Bradford abduction brace, coxa plana and, vi, 110
— coxa vara and, vi, 113
Bradford frame, acute traumatic spondylitis and, vi, 122
— bed-pans and, vi, 38
— emergency use of, vi, 40
— hip-joint and, vi, 34, 37
— rickets and, vi, 182
— scoliosis and, vi, 268
— spinal tuberculosis and, vi, 92
— spine and, vi, 37, 92
— tuberculosis of hip and, vi, 84
Bradycardia, electrocardiographic determination of, xviii, 172
— fetal, asphyxia and, ii, 196
Brain, abscess of, cerebrospinal fluid in, xx, 113
— anatomy of, iii, 212
— birth injuries of, i, 111, 137; iii, 224
— cysts of, iii, 250
— development of, x, 71, 73
— — factors causing failure of, x, 72
— edema of, i, 137
— — eclamptic uremia and, xix, 112
— — nephrosis and, xix, 82
— effect of skull fracture on, xv, 161
— fetal, calcium and, i, 139
— gumma of, neurosyphilis and, xvii, 206
— — treatment of, xvii, 281
— "heat center" of, ii, 50
— hemorrhage of, i, 111, 118, 139
Brain, rheumatic fever affecting, xviii, 18
— syphilis of, pathology of, xvii, 38
— tuberculosis of, relative frequency of, ix, 231
— tumors of, iii, 250
— — cerebrospinal fluid in, xx, 116
— — tuberculosis and, xiv, 348
— venous circulation of, v, 21
Brain abscess, accessory nasal sinus disease and, ix, 34
Brain fever, synonyms of, xiv, 265
Brain-pressure at birth, i, 112
Brain tumors, v, 117
— diagnosis of, v, 118
— gliomatous cyst, v, 120
— headache caused by, v, 117
— MacEwen's sign and, v, 118
— motor disturbances caused by, v, 118
— nystagmus caused by, v, 118
— ophthalmoscopic examination for, v, 19
— squint caused by, v, 118
— symptoms of, v, 117
— visual disturbances caused by, v, 118
— vomiting caused by, v, 118
— x-ray signs of, v, 118
Bronchial cysts, surgery of, xv, 183
Bronchial fistulæ, surgery of, xv, 184
Brandy, lobar pneumonia and, ix, 166
Braxton-Hicks version, placenta prævia and, i, 60
Bread, caloric value of, x, 193
— chemical content of, x, 288
— diet of pregnancy and, i, 23
— normal child and, x, 124
Breakfast, preventive pediatrics and importance of, iv, 63
Breast, anatomy and physiology of, xii, 156
— caking of, nursing and, viii, 97
— changes with fetal death in utero and, i, 50
— hygiene of, i, 141
— importance of complete and regular emptying of, xii, 164
— infection of, treatment of, xv, 224
— prenatal care of, i, 157
— streptococcic infection and, i, 93

Breast, tumors of, diagnosis of, xv, 225
Breast-fed infant, constipation in, viii, 221
— dyspepsia in, diagnosis of, viii, 160
— — etiology of, viii, 158
— — prognosis of, viii, 161
— — symptoms of, viii, 159
— — treatment of, viii, 160
Breast feeding, i, 139-148, 173
— addition of other foodstuffs and, iv, 48
— advantages of, ii, 139
— amount obtained at each, ii, 148
— anatomical factors in, iv, 46
— artificial feeding and, ii, 157
— caked breast interfering with, ii, 153
— colic and, i, 145
— complemental feeding, iv, 49; xii, 176, 177
— conditions preventing, ii, 150
— diarrhea prevented by, iv, 148; viii, 149
— diet of mother and, xii, 159, 166, 181
— difficult feeding cases, ii, 150
— "draft" and, xii, 164
— duration of each, xii, 174
— dystocia affecting, ii, 150
— early neonatal, i, 136
— education of mothers in, iv, 41
— harelip interfering with, ii, 155
— intervals in, xii, 167
— intracranial hemorrhage and, ii, 155
— management of, xii, 170
— mechanical factors in, iv, 46
— milk in, i, 139-148
— — examinations of, i, 144
— — quality and quantity of, i, 142-145
— — supply of, maternity institutions, i, 157
— mortality statistics showing value of, iv, 42
— physiology of, xii, 155
— preventive pediatrics and, iv, 41
— psychic factors influencing, ii, 151
— schedule for beginning, xii, 180
— schedule of, i, 174
Breast feeding, standards for successful nursing, xii, 184
— stools and, green, infants', i, 145
— supplementary feeding and, xii, 174, 177
— syphilitic infants and, i, 66
— technic of, iv, 42
— time limit, ii, 148
— tuberculous mothers and, i, 26, 29
— tumors preventing, ii, 154
— weakness in child and, ii, 154
— weaning and, xii, 179
— weight gain and, ii, 43
Breast milk, amount determined by weighing, ii, 133
— bacteriology of, xx, 121
— chemistry of, ii, 145; xx, 120
— composition of, ii, 144
— diet affecting quantity of, iv, 44
— eczema and, iii, 330
— fat in, x, 15
— harelip limiting supply of, iii, 134
— inauguration of secretion of, iv, 44
— manual expression of, iv, 46
— maternal diet and, iv, 43
— protein in, x, 12
— sepsis neonatorum and, iii, 16
— worry affecting amount of, iv, 50
Breast-pump, electric, illus., i, 144
— manual expression preferred to, iv, 46
— use of, i, 141, 142, 143
— — mastitis and, i, 147, 148
— value of, xii, 173
Breath-holding, iv, 76
Breath-holding spells, tetany and, x, 250
Breathing, abnormal types of, ix, 88
— cause of initial breath, ii, 52
— nasal, malnutrition from obstruction of, iv, 157, 160
— types of, ii, 52
Breathlessness, pregnancy and, i, 30
Breck feeding tube, xii, 104, 165, 190
Breech delivery, abruptio placentæ and, i, 56
— arm fractures in, i, 123
— clavicular fracture in, i, 121
— injuries at, i, 8, 111, 117, 123
— mortality rate of, i, 121
— placenta prævia and, i, 60

Breech delivery, pre-eclamptic patients and, collapse in, i, 131
— Smellie-Veit method, i, 118
— spinal cord injuries, i, 118
— stillbirths and, i, 117
— technic of, i, 128
— warmth essential to, i, 136
Breech presentation, cerebral palsies and, v, 142
— injury to nervous system by, v, 24, 142
— shape of head in, ii, 27
Brisement forcé, acute infectious arthritis and, vi, 57
Brissaud infantilism, charactersitics of, xiii, 147
Brittle bone, vi, 190
Brittle hair, xvi, 254
Brodie's abscess, vii, 71
— clinical features of, xv, 139
— syphilitic epiphysitis differentiated from, vii, 150
— treatment of, xv, 140
Broken compensation of heart, breast feeding and, ii, 150
— importance of prevention of, iv, 127
Bromidrosis, xvi, 275
Bromids, acute bronchitis caused by, ix, 102
— asthma and, ix, 116
— cough of enlarged non-tuberculous bronchial glands and, ix, 210
— dermatitis caused by, xvi, 48
— epilepsy and, v, 139
— sedative use of, respiratory diseases and, ix, 264
Bromoderma, blastomycosis differentiated from, xvi, 199
— dermatitis vegetans differentiated from, xvi, 220
— symptoms of, xvi, 48
Bronchi, anatomy of, iii, 68; ix, 84
— foreign bodies in, ix, 188; xv, 240
— hemorrhages of, iii, 82
— injuries of, iii, 82
— lymphatics of, ix, 86
— malformations of, iii, 81
— tumors of, iii, 86
Bronchial adenitis, character of cough of, ix, 100
Bronchial asthma, ix, 109
Bronchial breathing, ix, 93
Bronchial catarrh, ix, 107
Bronchial croup, ix, 106
Bronchial glands, anatomy of, ix, 247
— enlarged non-tuberculous, diagnosis of, ix, 209
— — incidence of, ix, 206, 231
— — physical examination of, ix, 207
— — treatment of, ix, 209
— tuberculosis of, diagnosis of, ix, 249; xiv, 341
— — pathology of, ix, 247
— — physical signs of, ix, 248
— — relative frequency of, ix, 231
— — symptoms of, ix, 248
Bronchial lymph-nodes, tuberculosis of, ix, 247
Bronchial pneumonia, thrombophlebitis causing, i, 94
Bronchiectasis, iii, 92
— bronchopneumonia and, ix, 130
— character of cough of, ix, 100
— fetal, cyanosis caused by, ii, 205
— foreign bodies causing, ix, 189
— pulmonary tuberculosis differentiated from, xiv, 351
— sputum in, characteristic appearance of, xx, 84
Bronchitis, acute, blood-count in, xi, 47
— — character of cough of, ix, 99
— — complications of, ix, 104
— — diagnosis of, ix, 104
— — etiology of, ix, 102
— — incidence of, ix, 101
— — pathology of, ix, 102
— — prognosis of, ix, 104
— — prophylaxis of, ix, 106
— — symptoms of, ix, 103
— — treatment of, ix, 105
— asthmatic, acute, ix, 109
— bronchopneumonia secondary to, ix, 122
— cattarhal, acute, ix, 101
— chronic, acute rhinitis and, ix, 6
— — adenoids causing, ix, 71
— — asthma causing, ix, 113
— — character of cough of, ix, 99
— — etiology of, ix, 107
— — prophylaxis of, ix, 109

Bronchitis, chronic, pulmonary tuberculosis differentiated from, xiv, 351
— — symptoms of, ix, 108
— — treatment of, ix, 108
— fibrinous, character of cough of, ix, 100
— — etiology of, ix, 106
— — symptoms of, ix, 106
— — treatment of, ix, 107
— hypertrophic rhinitis causing, ix, 12
— infant mortality and, iv, 111
— newborn, iii, 82
— plastic, ix, 106
— recurrent, accessory nasal sinus disease and, ix, 34
— rickets and, vii, 193
— spasmodic, acute, ix, 109
— tonsillectomy and, ix, 60
— tuberculous, prognosis of, ix, 238
— — symptoms of, ix, 237
— typhoid fever and, viii, 188
— weight curve in, ii, 45
Bronchophony, lobar pneumonia and, ix, 147
Bronchopneumonia, acute, abscess formation in, ix, 126
— — acute bronchitis differentiated from, ix, 104
— — acute congestive stage of, ix, 124
— — bronchial glands involvement in, ix, 126
— — bronchitis causing, ix, 101, 104
— — character of cough in, ix, 128
— — complications of, ix, 130
— — diagnosis of, ix, 131
— — distribution of lesions in, ix, 124
— — emphysema associated with, ix, 126
— — end results of, ix, 126
— — etiology of, ix, 121
— — gangrene and, ix, 126
— — glandular involvement in, ix, 126
— — gray stage of, ix, 125
— — incidence of, ix, 121
— — lobar pneumonia differentiated from, ix, 154
— — mottled red and gray stage of, ix, 124
— — pathology of, ix, 122
— — primary form of, ix, 129
Bronchopneumonia, acute, incidence of, ix, 122
— — prognosis of, ix, 131
— — prophylaxis of, ix, 136
— — respiration in, ix, 128
— — rhinitis causing, ix, 6
— — secondary form of, ix, 130
— — stages of, ix, 124
— — symptoms of, ix, 127
— — temperature in, ix, 127, 133
— — treatment of, ix, 134
— anemia secondary to, xi, 69
— blood-count in, xi, 47, 70, 72
— hemorrhagic disease confused with, ii, 236
— inanition and, x, 216
— infant mortality and, iv, 111
— leukocytosis in, xx, 48
— pulmonary tuberculosis differentiated from, xiv, 351
— rickets complicated by, xiii, 115
— scarlet fever complicated by, xiv, 22
— tuberculous, diagnosis of, ix, 240
— — prognosis of, ix, 240
— — symptoms of, ix, 238
— typhoid fever complicated by, xiv, 199
— whooping-cough complicated by, xiv, 124
Broths, bottle feeding supplemented by, xii, 132
Brow presentation, molding from, ii, 25
Brown-tailed moth, xvi, 161
Brudzinski's sign, infantile paralysis and, v, 104
— meningitis and, v, 85
Bryant's frame, suspension and, 110
Bubonic plague, newborn and, iii, 30
Buck's extension, description of, vi, 29
— hip-joint dislocations and, vi, 179
— hip sprain and, vi, 120
— spinal tuberculosis and, vi, 92
— tuberculosis of hip and, vi, 83
— tuberculosis of knee and, vi, 80
Buffer action, acidified and alkalinized milk and, xii, 20
Buhl's disease, atelectosis caused by, iii, 88

Buhl's disease, blood changes in, xx, 52
— cause of, iii, 4
— congenital cyanosis and, ii, 205
— diagnosis of, iii, 5
— hemorrhage and, iii, 185
— history of, iii, 4
— pathology of, iii, 4
— prognosis of, iii, 5
— symptomatology of, iii, 5
— treatment of, iii, 5
— Winckel's disease and, iii, 4
Bulbar hemorrhages, neonatal, i, 120
Bundle-branch block, electrocardiographic determination of, xviii, 177
Burns' blood concentration following, lactic acid acidosis caused by, xx, 171
— clinical features of, xv, 15
— fever and, xiii, 39
— prognosis of, xv, 16
— scar contractures following, vi, 201
— treatment of, xv, 17; xvi, 36
Bursæ, affections of, orthopedic management of, vi, 49, 216
— diseases of, bursitis, vii, 264
— — ganglion, vii, 264
Bursitis, vii, 264
— prepatellar, orthopedic management of, vi, 217
— subacromial, orthopedic management of, vi, 217
Butter, diet of pregnancy and, i, 165
Butter-flour mixtures (Czerny-Kleinschmidt), preparation of, xii, 39
Buttermilk, composition of, xii, 36
— infant feeding and, i, 145

Cabot's respiratory diagrams, ix, 92, 95, 96
Cabot's ring-bodies, significance of, xi, 13, 15
Cachectic purpura, blood changes in, xx, 53
Caffein, acute decompensation and, pregnancy and, i, 32
— asphyxia neonatorum and, ii, 201
— bronchopneumonia and, ix, 136
Caffein, lobar pneumonia and, ix, 166
— sepsis neonatorum and, iii, 17
— stimulant use of, respiratory diseases and, ix, 265
Caked breast, ii, 153
Calamine liniment, formula of, xvi, 346
Calamine lotion, formula of, xvi, 346
Calcaneovalgus, congenital, treatment of, vi, 286
Calcaneobursitis, orthopedic management of, vi, 216
Calcariuria, xix, 66
Calcification, cartilage, syphilitic infants and, i, 70-73
Calcium, amount in blood, xx, 131
— blood of newborn and, ii, 79
— blood in tetany and administration of, v, 135
— clotting and, ii, 232
— hemorrhagic diseases of newborn and, ii, 239
— milk and, xii, 18
— milk and plasma, ii, 143
— pollen fevers and, ix, 119
— rickets and faulty metabolism of, iv, 122
— teeth and, viii, 64
Calcium caseinate mixtures, infant feeding and, i, 145
Calcium chlorate, alimentary hemorrhage and, iii, 186
Calcium depositing vitamin, x, 24
Calcium medication, pregnancy and, i, 23, 139
Calcium salts, digestion and metabolism of, x, 39
Calculi, bladder, xix, 209
— — chronic pyelitis and, xix, 159
— renal, diagnosis of, xix, 182
— — formation of, xix, 180
— — symptoms of, xix, 181
— — treatment of, xix, 182
— salivary, iii, 197
— ureteral, chronic pyelitis and, xix, 159
— urinary, xv, 362
Callositas, xvi, 324
Callus, etiology of, xvi, 33
— peripheral nerve injury and, vi, 251

Callus formation, birth palsy and, i, 124
— fractures and, birth, i, 121, 127
Calomel, purgative use of, respiratory diseases and, ix, 263
Caloric requirement, average daily, xii, 67
Caloric value, carbohydrate, xiii, 14
— colostrum, ii, 144
— fat, xiii, 16
— protein, xiii, 16
Calories, daily loss in newborn of, ii, 38
— energy quotient and, xii, 160
— milk and, xii, 20, 27
— tables of various foods and, x, 192, 193
— typhoid delerium and, x, 213
Calot jacket, vi, 41
Calve's disease, tuberculosis of joints differentiated from, vi, 71, 83
Campbell-Mitchner knee splint, vi, 60
Camphor, accidental poisoning with, viii, 312
— acute rhinitis and, ix, 7
— bronchopneumonia and, ix, 136
— counterirritant use of, respiratory diseases and, ix, 258
— lobar pneumonia and, ix, 166
— stimulant use of, respiratory diseases and, ix, 266
Camphorated oil, asphyxia neonatorum and, ii, 201
— sepsis neonatorum and, iii, 17
Camps, summer, hygiene and, iv, 87
Cancer, breast feeding prevented by, ii, 150
— heredity and, iv, 11
— liver, iii, 201
— nursing and, iv, 48
Cancrum oris, viii, 30
Candy, appetite spoiled by, iv, 76
— diet of pregnancy and, i, 24, 165
— indigestion and, xii, 139
— preventive pediatrics and, iv, 63
Cane sugar, digestion of, xii, 48
— formula changes involving, xii, 85
— milk substitutes and, xii, 41
— relative value of, xii, 88
Canities, etiology of, xvi, 263
— incidence of, xvi, 262
Cantharides, acute bronchitis caused by, ix, 102
Capacity, newborn stomach, ii, 84
Capillary resistance, xx, 38
Caprokol, pyelitis treated with, i, 36
Capsicum, counterirritant use of, respiratory diseases and, ix, 258
Caput epididymidis, development of, xix, 5
Caput succedaneum, i, 112; iii, 391
— cephalematoma differentiated from, xv, 153
— diappearance of, ii, 32
— pressure in dry labor causing, v, 47
Carbohydrates, absorption of, xii, 46
— average ratio of, iv, 40
— caloric value of, xiii, 14
— — foods and, x, 192, 193
— digestion of, x, 33; xii, 46
— fermentation of, xii, 48
— foods containing, x, 28
— formula changes involving, normal infant and, xii, 85
— function of, x, 36
— human milk, xii, 162
— infant's requirements of, x, 17
— intestinal digestion of, viii, 142
— metabolism of, x, 33; xiii, 13
— milk containing, x, 27
— needs in older children, x, 17
— newborn digestion of, ii, 89
— principal functions of, x, 15
— tolerance for, xii, 47
Carbohydrate indigestion, character of stools in, xx, 72
Carbohydrate metabolism, disorders of, xx, 157
— tolerance tests and, xx, 159
Carbolic acid, dermatitis caused by, xvi, 42
Carbon-arc lamp, use of, vii, 231
Carbon dioxid, blood of newborn and, ii, 78
— hydrogen ion values and, ii, 98
— loss of, labor and, i, 130
— percentage in alveolar air, ii, 53
— prematurity and blood concentration of, ii, 166
— respiration initiated by blood content of, ii, 52

Carbon dioxid, respiratory alkalosis due to abnormal excretion of, xiii, 37
Carbon dioxid snow, nevi treated with, xv, 61
Carbon monoxid poisoning, alkalosis caused by, xx, 175
Carbonic acid, formation of, xiii, 26
Carbuncles, smallpox, xiv, 93
Carcinoma, heredity and, vi, 11
—nursing and, iv, 48
— primary, liver, iii, 201
Cardiac clinics, organization and administration of, xviii, 231
— source of patients of, xviii, 230
Cardiac conditions, pubescent, iv, 126
Cardiac disease, acquired, preventive pediatrics and, iv, 126
— congenital, unpreventability of, iv, 126
— malnutrition and, iv, 160
— pregnancy with, anesthesia and, i, 33
— — hereditary syphilis and, i, 67
— — induction and, premature labor, i, 33, 107
— — Karrel diet in, i, 37
Cardiac excitability, bromids for control of, respiratory diseases and, ix, 264
Cardiac infantilism, x, 142
Cardiovascular system, newborn, anatomy of, iii, 100
Carditis, rheumatic, subacute bacterial endocarditis differentiated from, xviii, 186
— — symptoms and signs of, xviii, 64, 80
— — temperature curve in, xviii, 66
Care, prenatal, i, 1-14
— — abortions and, i, 6, 44-48
— — diet of pregnansy and, i, 22-25
— — essentials of, i, 15-62
— — examination of patient and, i, 17-22
— — exhibits and, public health, i, 157
— — medical complications of pregnancy and, i, 25-62
— — organized, i, 12-14
— — prematurity and, i, 7
— — Public Health and, i, 149-175
Care, prenatal, directions for mothers in, i, 161
— — infant care and, i, 173
— — midwife and, i, 151, 154
— — New York City plan for, i, 155
— — purpose of, i, 5
— — sepsis and, i, 5
— — syphilitic infant deaths reduced by, i, 64, 82
Carious teeth, deciduous teeth and, viii, 64
— malnutrition and, iv, 160
— permanent teeth and, viii, 66
Carpenter-Haldane metabolism apparatus, xiii, 1
Carpopedal spasm, vii, 196
— tetany and, v, 130
Carrel-Dakin sterilization, acute osteomyelitis and, xv, 136
— burns and scalds and, xv, 20
— chronic empyema and, xv, 236
— skull fracture and, xv, 160
— suppurative pericarditis and, xv, 246
— wounds of soft parts and, xv, 8
Carriers, diphtheria, xiv, 182
— poliomyelitis, xiv, 230
— tetanus, xiv, 296
— typhoid, xiv, 206
Carrots, bottle feeding supplemented by, xii, 134
Cartilage, laryngeal, ix, 75
— newborn, characteristics of, ii, 48
Cartilage calcification, newborn, syphilis and, i, 37, 38
Cartilaginous exostoses, multiple, xv, 121
— — clinical signs and symptoms of, vii, 21
— — complications of, vii, 26
— — diagnosis of, vii, 25
— — etiology of, vii, 20
— — localization of lesions of, vii, 22
— — microscopic anatomy of, vii, 24
— — pathology of, vii, 23
— — symptoms of, vii, 21
— — treatment of, vii, 26
— — x-ray appearance of, vii, 25
Cascara, laxative use of, respiratory diseases and, ix, 262

Casec, composition of, xii, 36
Casein, ii, 145
— growth promoted by, x, 12
Casein milk, composition of, xii, 35
Castor oil, colic and, iii, 178
— purgative use of, respiratory diseases and, ix, 263
— use and abuse of, xii, 123
Casts, orthopedic, plaster-of-Paris, vi, 36
— "renal failure," xix, 35
— toxemias and, i, 37, 38
— urinary, pregnancy and, i, 21
— — significance of, xx, 17
Catalyzers, self-producing, growth and theory of, x, 78
Cataract, congenital, iii, 356
— detection of, v, 17
Catarrh, chronic nasal, ix, 9
— postnasal, ix, 9
— transitional, ii, 119
Catarrhal bronchitis, acute, ix, 101
Catarrhal croup, ix, 79
Catarrhal fever, acute, ix, 1
Catarrhal gastritis, acute, pathology of, viii, 104
— — symptoms of, viii, 105
— — treatment of, viii, 105
Catarrhal jaundice, blood-count in, xi, 55
— character of stools in, xx, 74
— incidence of, viii, 326
— treatment of, viii, 327
Catarrhal laryngitis, measles complicated by, xiv, 45
Catarrhal pharyngitis, acute, treatment of, viii, 39
Catarrhal pneumonia, ix, 121
Catarrhal spasm, ix, 79
Catarrhal stomatitis, etiology, viii, 22
— symptoms and treatment of, viii, 23
Cathartics, ii, 137
— therapeutic use of, respiratory diseases and, ix, 262
Catheter, tracheal, mucus removed with, ii, 124
Catheterization, xv, 349
— kidney pelvis, pyelitis of pregnancy and, i, 36
Cathodal closing contractions, tetany and, v, 132
Cathodal opening contraction, tetany and, v, 133
Caudate and lenticular nuclei, anatomy of, v, 71
Cauliflower, bottle feeding supplemented by, xii, 134
Causes of postural defects in infancy, iv, 36
Caustic alkalies, accidental poisoning with, viii, 310
Cavernous angioma, xvi, 4
Cavernous lymphangiomata, surgical aspects of, xv, 62
Celery, bottle feeding supplemented by, xii, 134
Celiac disease, blood-sugar and, xx, 161
— complications of, viii, 213
— course of, viii, 212
— diagnosis of, viii, 213
— diet in, viii, 215
— etiology of, viii, 207
— infantilism and, x, 140
— nomenclature and history of, viii, 206
— pathology and physiology of, viii, 208
— prognosis of, viii, 217
— symptoms of, viii, 208
— treatment of, viii, 214
Celiac rickets, calcium loss causing, xx, 177
Cell, inanition inhibiting growth of, x, 203
Cell counts, spinal fluid, xvii, 52
Cellulitis, acute osteomyelitis differentiated from, xv, 135
— cervical, surgery of, xv, 191
— crab, xvi, 215
— orbital, accessory nasal sinus disease and, ix, 34
— pelvic, postpartum care and, i, 161
— puerperal infections and, i, 89, 93
— puerperal ulcer causing, i, 88
— scalp, xv, 154
Centimeters and inches, equivalent table of, x, 290
Central nervous system, newborn, hemorrhage in, i, 118-120
— tuberculosis of, xiv, 345

Central pneumonia, Lésne's scalene sign in, ix, 148
Cephalalgia, epidemic, synonyms of, xiv, 265
Cephalematoma, iii, 392
— definition of, xv, 152
— disappearance of, ii, 32
— newborn, i, 112
Cephalhydrocele, cephalematoma differentiated from, xv, 153
Cephalic injuries, birth, i, 8, 112
Cephalocele, definition of, xv, 151
Cereals, bottle feeding supplemented by, xii, 131
— caloric value of, x, 193
— chemical composition of, x, 287
— diet of pregnancy and, i, 22
— late infancy diet and, iv, 55
— laxative preparations of, xii, 132
— normal child and, x, 123
— unmilled, breast feeding and, iv, 49
Cereal milk, preparation of, xii, 38
Cerebellar decompression, hernia following, v, 120
Cerebellar palsies, rarity of fixed lesions of, v, 144
Cerebellum, development of, x, 72
— disorders of, v, 217
Cerebral abscess, epidemic encephalitis differentiated from, xiv, 261
Cerebral compression, skull fractures and, xv, 161
Cerebral contusion, iii, 224
Cerebral cortex, convulsions caused by anemia of, v, 128
— disorders affecting, v, 218
Cerebral decompression, v, 146
Cerebral embolism, labor and, i, 11, 33
— pleurisy with effusion and, ix, 198
Cerebral hemorrhage, breech delivery and, i, 114
— labor and, i, 150
— — stillbirths and, i, 112
— late manifestations of, xii, 142
— mortality due to, ii, 3
— newborn, i, 113, 137
— — deaths due to, i, 111
— operative delivery and, i, 114
— prematurity and, i, 114
— spontaneous delivery and, i, 114
Cerebral hemorrhage, whooping-cough causing, v, 81
Cerebral lesions, delayed speech due to disturbance of control of, v, 196
Cerebral palsy (paralysis), abdominal reflex and, v, 12
— acrocephaly and, v, 54
— albuminuria and, v, 142
— Babinski's sign in, v, 149
— birth injury causing, v, 20, 142, 149
— convulsions and, v, 150
— decompression in, v, 146
— definition of, v, 141
— diphtheria causing, v, 142
— drooling in, v, 149
— education and, v, 152
— encephalitis causing, v, 142
— extrapyramidal type of, v, 148
— familial, v, 147
— general discussion, v, 141
— hemorrhage causing, v, 149
— hydrocephalus causing, v, 150
— infantile, iii, 223
— infections producing, v, 142, 147
— "infectious diarrhea" causing, v, 142
— injury causing, v, 149
— institutional care for, v, 147
— operations for relief of contractures following, v, 144
— paralysis agitans type of, v, 149
— parity and, v, 142
— physiotherapy for, v, 146
— pneumonia and, v, 150
— prenatal influences, v, 141
— prognosis of, v, 142
— progressive muscular atrophy and, v, 69
— reduction of nerve supply for contractures following, v, 145
— section of posterior roots in, v, 145
— spastic type of, v, 143
— — diagnosis of, vi, 239
— — etiology of, vi, 237
— — pathology of, vi, 238
— — symptoms of, vi, 238
— — treatment of, vi, 240
— types of disturbances in, v, 144

1964

Cerebral palsy (paralysis), whooping-cough causing, v, 142, 150
Cerebral poliomyelitis, vi, 218
Cerebral shock, skull fractures and, xv, 161
Cerebral spastic paralysis, vii, 246
Cerebral stridor, iii, 73
Cerebral syphilis, epidemic encephalitis differentiated from, xiv, 261
Cerebral tumors, epidemic encephalitis differentiated from, xiv, 261
Cerebrospinal fluid, amount obtained by puncture, v, 14
— cell count, v, 15
— cerebrospinal meningitis and, xiv, 278
— chemistry of, xx, 95
— — tuberculous meningitis and, v, 97
— circulation of, v, 4, 112
— clotting tested, v, 16
— colloidal gold reaction on, xvii, 55
— discontinuity of pressure of, v, 23
— examination of, v, 14
— formation of, v, 5
— function of, xx, 95
— globulin in, v, 16; xvii, 54
— glucose in, xvii, 54
— icterus neonatorum and, ii, 219
— interpretation of, v, 13
— laboratory examination of, xvii, 51
— — neurosyphilis and, xvii, 179
— neurosyphilis and clinical changes in, xvii, 186
— normal, albumin in, xx, 97
— — amount of, xx, 97
— — chlorids in, xx, 99
— — cytology of, xx, 97
— — globulin in, xx, 98
— — physical characteristics of, xx, 97
— — protein in, xx, 97
— — pressure of, xx, 97
— — sugar in, xx, 98
— origin of, v, 111
— pathology of, xx, 100
— physiology of, xx, 94
— poliomyelitis and, xiv, 241, 242
— pressure at birth, ii, 110
— pressure taking, v, 13
— protein percentage in, v, 16
Cerebrospinal fluid, serological examination of, importance of, xx, 69
— sugar in, v, 16
— tapping for, diagnostic indications for, xx, 95
— — technic of, xx, 96
— — therapeutic indications for, xx, 95
— xanthochromia of, ii, 110
Cerebrospinal hemorrhage, breech deliveries and, i, 117
Cerebrospinal meningitis, v, 84
— bacteriology of, xiv, 266, 280
— blood-count in, xi, 47
— causes of, v, 85
— clinical types of, xiv, 276
— complications of, xiv, 282, 291
— congenital syphilis and, iii, 49
— convulsions and, v, 137
— definition of, xiv, 265
— diagnosis of, xiv, 280
— dissemination of, xiv, 268
— epidemic encephalitis differentiated from, xiv, 261
— epistaxis and, ix, 18
— etiology of, xiv, 269
— herpes simplex and, xvi, 86
— history of, xiv, 265
— hydrocephalus caused by, v, 114
— incubation period of, xiv, 270
— laboratory findings in, xiv, 278
— lumbar puncture in, v, 86
— meningococcus causing, v, 89
— pathology of, xiv, 271
— prognosis of, xiv, 285
— prophylaxis of, xiv, 287
— Public Health regulations for, xiv, 293
— purulent forms of, v, 95
— reflexes in, v, 85
— sequelæ of, xiv, 293
— serum disease and, xiv, 292
— serum injection, v, 90, 96
— serum treatment of, xiv, 288
— symptoms of, xiv, 273
— synonyms of, xiv, 265
— terminology of, xiv, 265
— treatment of, xiv, 287
— tuberculous, v, 96
— types of, xiv, 276

Cerebrospinal meningitis, yeasts causing, v, 89
Cerebrospinal pressure, conditions associated with increase of, xx, 95
Cerium oxalate, nausea of pregnancy treated with, i, 25
— acute, surgery of, xv, 189
— acute follicular tonsillitis causing, ix, 54
— chronic tonsillitis and, ix, 60
— tuberculous, xv, 192
Cervical amputation, abortion and, i, 45
Cervical auricles, surgery of, xv, 188
Cervical cellulitis, surgery of, xv, 191
Cervical glands, anatomy of, ix, 245
— tuberculosis of, diagnosis of, ix, 246; xiv, 342
— — pathology of, ix, 245
— — relative frequency of, ix, 231
— — symptoms of, ix, 246
— — treatment of, ix, 247
Cervical nerves, newborn, rupture of, birth palsy from, i, 124, 125
Cervical ribs, surgery of, xv, 188
Cervical vertebræ, newborn, fractures of, breech delivery and, i, 8
Cervix uteri, abortion and, i, 29, 45, 48
— abruptio placentæ and, i, 55
— argyrol treatment of, gonorrhea and, i, 61
— asepsis of, labor and, i, 109
— cardiac cases and, i, 33
— dilatation of, i, 55, 60, 89, 91, 96, 109
— — rubber bags used in, i, 32
— fetal death in utero and, i, 50
— lacerations of, i, 45, 89, 91
— — repair, i, 97
— multipara cases and, i, 108
— placenta prævia and, i, 59, 60
— puerperal infections and, i, 89, 91, 96
— tamponage of, i, 48, 50, 110
Cesarean section, i, 128
— abortion and, i, 43
— abruptio placentæ and, i, 56
— bacteriology of newborn and, ii, 119
— cardiac disease and, i, 32, 33
Cesarean section, conservatism in, i, 19
— death in utero prevented by, i, 49, 107
— eclampsia and, death-rate in, i, 92
— indications for, i, 107
— ovarian tumor and, i, 41
— placenta prævia and, i, 60
— shape of head found at, ii, 27
— toxemias of pregnancy and, i, 38
— tuberculous women and, i, 29
Chafing, iii, 320
Champetier de Ribes colpeurynter, i, 108
Chancre, pathology of, xvii, 41
Changes in constituents, normal infant feeding and, xii, 81, 93
Changes in formula, normal infant feeding and, xii, 76, 93
Changes in intervals, normal infant feeding and, xii, 80
Charcot joint, practically unknown in childhood, vii, 140
Charcot-Leyden crystals, asthma and, ix, 112, 113
Charcot-Marie-Tooth, neural progressive muscular atrophy of, v, 69, 215
— progressive neural muscular atrophy of, vii, 252
Charts, hospital, newborn, ii, 134
Cheese, diet of pregnancy and, i, 23
Chemical agents, dermatitis caused by, xvi, 33, 41, 47
Chemical poisons, anemia caused by, xi, 80; xx, 50
— blood-count and, xi, 54
Chemical urinanalysis, routine, xx, 4
Chemistry, newborn blood, ii, 73
Chenopodium, accidental poisoning with, viii, 312
Chest, aspiration of, empyema and, xv, 231
— auscultation of, ix, 91
— auscultatory percussion of, ix, 97
— circumference during first 12 days, ii, 33
— closed intercostal drainage of, empyema and, xv, 232
— cold on, ix, 101
— development of, x, 62, 74, 77

Chest, diameter of, ii, 33
— early diminution in size of, ii, 33
— examination of, ix, 87
— — auscultation, ix, 91
— — auscultatory percussion, ix, 97
— — inspection, ix, 88
— — palpation, ix, 90
— — percussion, ix, 94
— foreign bodies in, xv, 240
— funnel, vii, 49
— injuries of, subcutaneous emphysema, xv, 220
— — surgery of, xv, 218
— inspection of, ix, 88
— measurements to ten years, iv, 30
— palpation of, ix, 90
— percussion of, ix, 94
— proportions of, ii, 28
— rib resection and drainage of, empyema and, xv, 232
— siphon drainage of, advantages of, xv, 233
— size at birth, ii, 13, 23
— surgery of, diaphragmatic hernia, xv, 247
— — empyema, xv, 225, 231
— — eventration of diaphragm, xv, 253
— — examination of, xv, 6
— — foreign bodies, xv, 240
— — lung abscess, xv, 236
— — mastitis, xv, 221
— — mediastinitis, xv, 246
— — suppurative pericarditis, xv, 244
— — tuberculosis of ribs and sternum, xv, 225
— — tumors of breast, xv, 225
— — tumors of mediastinum, xv, 247
Cheyne-Stokes respiration, cyanosis and, ii, 206
— intracranial hemorrhage and, v, 43
— significance of, ix, 89
Chicken, diet of pregnancy and, i, 23
Chicken blood, lobar pneumonia and, ix, 167
Chicken lice, xvi, 159
Chickenpox, blood-count in, xi, 47
— complications of, xiv, 74
— definition of, xiv, 69
— diagnosis of, xiv, 75
— differential diagnosis of, xiv, 76
Chickenpox, etiology of, xiv, 70
— history of, xiv, 69
— incubation period of, xiv, 71
— newborn, iii, 23
— papular urticaria differentiated from, xvi, 80
— pathology of, xiv, 70
— prevention of, iv, 138; xiv, 77
— prognosis of, xiv, 77
— Public Health regulations for, xiv, 78
— rheumatic infections and, xviii, 78
— sequelæ of, xiv, 74
— smallpox differentiated from, xiv, 76, 94
— symptoms of, xiv, 71
— synonyms of, xiv, 69
— treatment of, xiv, 77
— vaginitis associated with, xix, 229
— whooping-cough predisposing to, xiv, 126
Chigger, xvi, 168
Chilblain, diagnosis of, xvi, 38
— etiology of, xvi, 37
— prognosis of, xvi, 38
— symptoms of, xvi, 37
— treatment of, xvi, 38
Child conservation, abortion and, i, 6
— prenatal care and, i, 12, 15
— Public Health measures for, i, 150-175
Child feeding, additions to bottle feeding, xii, 129-135
— art of, xii, 143
— breast feeding, xii, 155, 170
— convulsions as a symptom, xii, 141
— definition of, xii, 4
— eating between meals, xii, 138
— essential points in, xii, 64
— food changes in, gastric indigestion and, xii, 109
— — intestinal indigestion and, xii, 118
— food requirements in normal children, xii, 57
— food requirements in premature infant, xii, 96, 102
— formula changes in normal infant, xii, 76
— formulas for, xii, 69, 72
— growth and development and, xii, 7

Child feeding, intervals in, xii, 137
— introductory remarks, xii, 1
— later infancy and childhood, xii, 136
— milk—its source and preparation, xii, 9, 14
— peculiarities in expression of disease, xii, 139
— physiological action of food constituents, xii, 44
— physiology of digestion, xii, 54
— preparations from milk, xii, 23
— psychology of infancy and, xii, 149
— reflexes and, xii, 140
— regularity in, xii, 137
— schedules for, xii, 137
— selective eaters, xii, 139
— standards for successful nursing, xii, 184
— substitutes for milk, xii, 34
— tolerance, xii, 7, 140
Childhood, acquired syphilis in, xvii, 233
— — incidence of, xvii, 241
— — significant peculiarities of, xvii, 240
— blood-pictures during, second to seventh years, xi, 43
— — seventh to twelfth years, xi, 44
— convulsions during, v, 136
— disorders of carbohydrate metabolism in, general considerations of, xx, 157
— eczema in, xvi, 115
— gastric contents in, information derived from examination of, xx, 89
— incidence of syphilis in, xvii, 90
— — discussion and summary of, xvii, 93
— — general considerations of, xvii, 85
— infectious diseases of, acute rheumatic fever, xiv, 388
— — cerebrospinal meningitis, xiv, 265
— — chickenpox, xiv, 69
— — diphtheria, xiv, 153
— — epidemic encephalitis, xiv, 254
— — erysipelas, xiv, 399
— — erythema infectiosum, xiv, 320
— — German measles, xiv, 62
Childhood, infectious diseases of, influenza, xiv, 379
— — introduction to, xiv, 1
— — malaria, xiv, 209
— — measles, xiv, 34
— — mumps, xiv, 141
— — poliomyelitis, xiv, 224
— — rabies, xiv, 324
— — scarlet fever, xiv, 10
— — septic sore-throat, xiv, 308
— — smallpox, xiv, 80
— — tetanus, xiv, 296
— — tuberculosis, xiv, 332
— — typhoid fever, xiv, 188, 196
— — vaccinia, xiv, 104
— — whooping-cough, xiv, 117
— intestinal parasites in, pathogeniety of, xx, 76
— latent syphilis in, incidence of, xvii, 208
— leukemia in, xi, 132, 161
— malnutrition in, iv, 154
— morbidity and mortality in, iv, 105
— nervous disorders affecting, v, 212
— neurosyphilis in, clinical manifestations of, xvii, 185
— — criteria of diagnosis of, xvii, 174
— — general considerations of, xvii, 173
— — incidence of, xvii, 175
— — laboratory examination of spinal fluids in, xvii, 179
— normal blood chemistry values in, xx, 129
— pneumonia in, bacteriology of, xx, 85
— reaction of hematopoietic system in, xi, 21
— serological tests in, interpretation of, xvii, 46
— specific disease prevention in, iv, 122
— surgery of, abdomen, xv, 272
— — abdominal contusions, xv, 296
— — abdominal tuberculosis, xv, 302
— — acidosis, xv, 24
— — acute cervical adenitis, xv, 189
— — acute intussusception, xv, 313
— — acute retropharnygeal abscess, xv, 178

Childhood, surgery of, acute suppurative sialo-adenitis, xv, 188
— — adhesion of clitoris and prepuce, xv, 355
— — adrenal tumors, xv, 369
— — alkalosis, xv, 26
— — anal fissure, xv, 345
— — appendicitis, xv, 305
— — back, xv, 206
— — blood diseases, xv, 50
— — bone diseases, xv, 118
— — bone tuberculosis, xv, 140
— — bone tumors, xv, 125
— — branchial cysts, xv, 183
— — branchial fistulæ, xv, 184
— — Brodie's abscess, xv, 139
— — burns and scalds, xv, 15
— — cellulitis of neck, xv, 191
— — cervical auricles, xv, 188
— — cervical ribs, xv, 188
— — chest, xv, 218
— — choice of anesthetic, xv, 29
— — circumcision, xv, 353
— — clinical examination in, xv, 3
— — congenital hypertrophic pyloric stenosis, xv, 283
— — congenital kidney anomalies, xv, 364
— — congenital sacrococcygeal sinuses and fistulæ, xv, 217
— — congenital syphilis, xv, 46
— — congenital tongue-tie, xv, 174
— — cystic hygroma, xv, 197
— — cysts of face, xv, 173
— — dehydration, xv, 22
— — developmental bone disease, xv, 119
— — developmental errors of gastro-intestinal tract, xv, 272
— — diaphragmatic hernia, xv, 247
— — empyema, xv, 225, 231
— — enteric cysts, xv, 339
— — epididymis and testis, xv, 371
— — epigastric hernia, xv, 266
— — epispadias, xv, 359
— — ether administration, xv, 30
— — eventration of diaphragm, xv, 253
— — exstrophy of bladder, xv, 357
— — face and mouth, xv, 166
— — femoral hernia, xv, 265
Childhood, surgery of, fistula in ano, xv, 348
— — foreign bodies in chest, xv, 240
— — fractures and epiphyseal separations, xv, 66
— — general considerations of, xv, 1
— — genito-urinary, xv, 349
— — goiter, xv, 200
— — harelip and cleft-palate, xv, 166
— — head, xv, 151
— — hemangiomata, xv, 57
— — hemolytic jaundice, xv, 54
— — hemophilia, xv, 53
— — hemophilic or bleeder's joint, xv, 149
— — hemorrhoids, xv, 348
— — hernia, xv, 256
— — hydrocele, xv, 266
— — hydrophobia, xv, 11
— — hyperthyroidism, xv, 202
— — hypospadias, xv, 355
— — imperfectly descended testis, xv, 267
— — inguinal hernia, xv, 259, 263
— — injuries of chest, xv, 218
— — intestinal obstruction, xv, 320
— — jaundice in sepsis of newly born, xv, 311
— — jaw, xv, 181
— — joint diseases, xv, 144
— — liver and bile-ducts, xv, 330
— — lung abscess, xv, 236
— — lymphangiomata, xv, 62
— — macroglossia, xv, 175
— — macrostomia, xv, 173
— — malformations of anus and rectum, xv, 341
— — mastitis, xv, 221
— — mediastinitis, xv, 246
— — megacolon, xv, 322
— — neck, xv, 183
— — omental and mesenteric cysts, xv, 338
— — Osgood-Schlatter's disease, xv, 141
— — osteomyelitis, xv, 129, 137
— — perianal and ischiorectal abscess, xv, 347
— — peritonitis, xv, 299
— — peritonsillar abscess, xv, 180
— — phimosis, xv, 352

Childhood, surgery of, postoperative care, xv, 31
— — precautions during operation, xv, 30
— — preoperative care, xv, 28
— — prolapse of rectum, xv, 345
— — pyelitis, xv, 359
— — pyloric stenosis, xv, 283
— — quinsy, xv, 180
— — rabies, xv, 11
— — ranula, xv, 176
— — rectal polyp, xv, 344
— — rectum and anus, xv, 341
— — renal cysts, xv, 364
— — retroperitoneal abscess, xv, 311
— — rickets, xv, 41
— — sacrococcygeal tumors, xv, 215
— — sarcoma of intestine, xv, 339
— — scurvy, xv, 34
— — shock, xv, 23
— — spina bifida, xv, 206, 215
— — splenic anemia and Gaucher's disease, xv, 335
— — suppurative pericarditis, xv, 244
— — synovitis and arthritis, xv, 145
— — tetanus, xv, 9
— — thymus, xv, 203
— — thyroglossal cysts and fistulæ, xv, 185
— — thyroid, xv, 200
— — torsion of spermatic cord, xv, 271
— — tranfusion, xv, 32
— — tuberculosis of cervical glands, xv, 192
— — tuberculosis of kidney, xv, 365
— — tuberculosis of ribs and sternum, xv, 225
— — tumor incidence, xv, 56
— — tumors of breast, xv, 225
— — tumors of kidney, xv, 366
— — tumors of mediastinum, xv, 247
— — tumors of ovary, xv, 337
— — tumors of testis, xv, 372
— — ulcers of frenum, xv, 175
— — umbilical affections, xv, 281
— — umbilical hernia, xv, 256
— — urinary lithiasis, xv, 362
— — ventral hernia, xv, 265
— — Vincent's angina, xv, 180
— — wounds of soft parts, xv, 8
Childhood, syphilis in, adult syphilis differentiated from, xvii, 2
— — incidence of, xvii, 85, 93
— — treatment of, xvii, 258
— tuberculosis in, iv, 143
— tuberculosis of, adrenal, xiv, 355
— — bone and joint, xiv, 356
— — bronchial gland, xiv, 340
— — central nervous system and, xiv, 345
— — cervical gland, xiv, 342
— — diagnosis of, xiv, 340
— — ear and, xiv, 349
— — etiology of, xiv, 337
— — eyes and, xiv, 348
— — gastro-intestinal system, xiv, 352
— — introduction, xiv, 332
— — laboratory methods, xiv, 359
— — liver, xiv, 354
— — lupus vulgaris, xiv, 344
— — miliary, xiv, 355
— — modes of invasion of, xiv, 339
— — primary mesenteric node, xiv, 343
— — psychic disturbances due to, xiv, 355
— — Public Health regulations, xiv, 372
— — pulmonary, xiv, 350
— — renal, xiv, 355
— — respiratory system, xiv, 350
— — roentgenology, xiv, 361
— — serology, xiv, 369
— — spleen, xiv, 355
— — symptomatology of, xiv, 340
— — treatment, xiv, 362
Childhood morbidity, iv, 120
Childhood mortality, iv, 118
— chief factors affecting, iv, 12
Child hygiene, education and, iv, 172
— historical considerations of, iv, 171
— infant welfare and, iv, 177
— prenatal clinics and, iv, 176
— preschool children and, iv, 179
— preventive pediatrics and, iv, 169
— Public Health nurses and, iv, 175
— school hygiene and, iv, 180
Child life, functional periods of, x, 72

Child life, sociological periods of, x, 50
Children, acquired syphilis in, pathology of, xvii, 41
— carbohydrate requirement of, x, 17
— fat ingestion by, x, 30
— fat requirements of, x, 15
— hypnotism of, xix, 56
— protein needs in, x, 13
— pyelitis in, symptoms of, xix, 148
— transmission of immunity by syphilitic mother to, xvii, 74
Chilling, avoidance of, pregnancy and, i, 162
— skin, newborn, i, 138
Chills, thrombophlebitis, i, 93
Chills and fever, synonyms of, xiv, 209
Chin, early contour of, ii, 12
Chin cough, synonyms of, xiv, 117
Chironomidæ, xvi, 160
Chloasma, symptoms and treatment of, xvi, 288
— vitiligo differentiated from, xvi, 293
Chloral hydrate, convulsions controlled by, iii, 248
— convulsions of pregnancy treated with, i, 38
— dermatitis caused by, xvi, 48
— sedative use of, respiratory diseases and, ix, 264
— tetanus neonatorum and, iii, 34
Chlorids, amount in blood, xx, 131
— cerebrospinal, normal, xx, 99
Chlorid of lime, asepsis of labor with, i, 86
Chlorin, respiratory affections and, ix, 8
— urine and, ii, 106
Chlorin salts, digestion and metabolism of, x, 41
Chloroform, Buhl's disease and poisoning with, iii, 4
— convulsions contraindicating, i, 38
— hemorrhagic disease and, ii, 232
— pregnancy and labor and, i, 170
— urine analysis and, i, 21
— use during labor, ii, 123
Chloroma, blood-picture of, xi, 171
— case history of, xi, 170
— diagnosis of, xi, 172
Chloroma, etiology of, xi, 169
— first description of, xi, 169
— leukemia and, xi, 130, 169, 172
— myeloma and, xi, 131, 169, 172
— physical signs of, xi, 171
— symptoms of, xi, 170
— treatment of, xi, 172
Chlorosis, anemia of, xi, 85
— blood-picture in, xi, 87, 100
— diagnosis of, xi, 87
— epistaxis and, ix, 18
— original description of, xi, 3
— premature signs resembling, ii, 167
— symptoms of, xi, 86
— treatment of, xi, 87
Chocolate, contraindicated in pregnancy, i, 24
Choked disc, encephalitis and, v, 99
Cholecystitis, incidence of, viii, 328; xv, 333
Cholelithiasis, incidence of, viii, 328; xv, 333
— newborn, iii, 204
Cholera, milk as carrier of, xx, 122
Cholera infantum, viii, 168
— dehydration and, xiii, 42
Cholesterin, ii, 92
— blood of newborn and, ii, 79
Cholesterol, amount in blood, xx, 132
Chondrodysplasia fœtalis, vi, 192
Chondrodystrophy fœtalis, vii, 11
— bodily changes in, vii, 19
— body growth and, vii, 14
— character of, iii, 302
— course of, iii, 306
— diagnosis of, iii, 305; xiii, 151
— etiology of, iii, 303; vii, 14
— metabolism in, xiii, 151
— morbid anatomy of, xiii, 147
— pathology of, iii, 303; vii, 14
— prognosis of, xiii, 152
— signs and symptoms of, xiii, 148
— symptoms of, iii, 304
— treatment of, vii, 19; xiii, 152
— x-ray studies of, vii, 18
Chondroma, joints and, vi, 126
— solitary, character of, vii, 160
— treatment of, vi, 193; xv, 127
Chordæ tendineæ, pathological physiology of, xviii, 44

Chorea, acute rheumatic fever causing, vii, 95; xiv, 394
— adenoids and, ix, 70
— brain pathology and, xviii, 18
— cardiac disease and, iv, 126
— chickenpox followed by, xiv, 75
— convalescent care of, xviii, 63
— diagnosis of, xviii, 59
— differential diagnosis of, xviii, 61
— epidemic encephalitis and, v, 98
— Friedreich's ataxia resembling, vi, 250
— Huntington's, heredity and, iv, 8
— — marriage and, iv, 10
— lenticular degeneration and, v, 72
— neurosyphilis and, xvii, 207
— "sleeping sickness" and, v, 98
— symptoms and signs of, xviii, 59
— tonsillectomy and, ix, 60
— treatment of, xviii, 62
Chorioretinitis, latent syphilis and, xvii, 225
— syphilitic, incidence of, xvii, 147
Choroid plexus, ophthalmoscope and tubercles of, v, 96
— origin of cerebrospinal fluid and, v, 111
Choroid tubercles, rarity of, v, 17
Choroiditis, syphilitic, pathology of, xvii, 36
Chromidrosis, xvi, 276
Chronic adrenal insufficiency, symptoms of, xiii, 93
— treatment of, xiii, 94
Chronic appendicitis, diagnosis of, xv, 310
Chronic arthritic disease, progressive, course of, vii, 104
— — diagnosis of, vii, 104
— — etiology of, vii, 99
— — nomenclature of, vii, 98
— — pathology of, vii, 102
— — prognosis of, vii, 105, 107
— — signs and symptoms of, vii, 103
— — treatment of, vii, 106
Chronic atrophic rhinitis, ix, 13
— late inherited syphilis and, xvii, 171
Chronic bacterial infections, nutritional needs and, xii, 6
Chronic basilar meningitis, cerebrospinal fluid in, xx, 112
Chronic blennorrhea, ix, 9
Chronic bronchitis, acute rhinitis and, ix, 6
— asthma causing, ix, 113
— character of cough of, ix, 99
— etiology of, ix, 107
— prophylaxis of, ix, 109
— pulmonary tuberculosis differentiated from, xiv, 351
— symptoms of, ix, 108
— treatment of, ix, 108
Chronic cerebrospinal meningitis, xiv, 277
Chronic constipation, character of stools in, xx, 73
— older children and, viii, 226
Chronic coryza, ix, 9
— syphilis causing, iii, 52
Chronic cryptic tonsillitis, ix, 57
Chronic diffuse nephritis, chyluria in, xix, 67
Chronic diffuse nephropathy, renal lesions in, xix, 125
— vascular lesions in, xix, 127
Chronic empyema, treatment of, xv, 236
Chronic encephalitis, case history of, v, 100
Chronic fibrous osteomyelitis, vii, 80
Chronic gastric indigestion, treatment of, viii, 107
Chronic glomerular nephritis, blood chemistry in, xx, 150
— clinical features of, xx, 148
Chronic hyperplastic laryngitis, diagnosis of, ix, 81
— treatment of, ix, 82
Chronic hypertrophic tonsillitis, ix, 57
Chronic inanition, xiii, 25
Chronic infections, malnutrition and, iv, 162
Chronic infectious arthritis, clinical course of, vi, 103
— diagnosis of, vi, 104
— etiology of, vi, 102
— pathology of, vi, 103
— prognosis of, vi, 105
— symptoms of, vi, 103
— treatment of, vi, 105
— types of, vi, 103
— x-ray and, vi, 104

Chronic infectious diseases, blood-pictures in, xi, 53
Chronic infectious spondylitis, symptoms of, vi, 104
Chronic interstitial nephritis, blood chemistry in, xx, 153
— clinical features of, xx, 152
Chronic interstitial pneumonia, ix, 168
Chronic intestinal indigestion, character of stools in, xx, 73
— description of, viii, 204
— infantilism and, x, 140
— treatment of, viii, 205
Chronic intussusception, incidence of, xv, 317
Chronic lacumen tonsillitis, ix, 57
Chronic laryngitis, hyperplastic, ix, 81
— obstruction caused by, ix, 83
— syphilitic, ix, 82
— tuberculous, ix, 82
Chronic lymphatic leukemia, blood changes in, xi, 145, 147; xx, 58
— case history of, xi, 143
— diagnosis of, xi, 147
— symptoms of, xi, 146
— treatment of, xi, 148
Chronic malaria, symptoms of, xiv, 217
Chronic malnutrition, fat intolerance and, x, 31
Chronic myelogenous leukemia, blood-count of, xi, 158
— case history of, xi, 156
— symptoms of, xi, 159
— treatment of, xi, 160
Chronic nasal catarrh, ix, 9
Chronic nasopharyngitis, ix, 9
Chronic nephritis, acidosis in, xx, 173
— classification of, xx, 148
Chronic osteomyelitis, vii, 69
— clinical signs of, vii, 71
— complications of, vii, 71
— treatment of, vii, 72, 73; xv, 139
— x-ray diagnosis of, vii, 72
Chronic parenchymatous tonsillitis, ix, 57
Chronic pemphigus, xvi, 98
Chronic phthsis, ix, 241
Chronic pneumonia, diagnosis of, ix, 170
Chronic pneumonia, empyema differentiated from, ix, 200
— etiology of, ix, 168
— pathology of, ix, 169
— symptoms of, ix, 169
— treatment of, ix, 170
Chronic pulmonary tuberculosis, diagnosis of, ix, 242
— pathology of, ix, 241
— prognosis of, ix, 243
— symptoms of, ix, 242
Chronic pyelitis, absent local symptoms in, xix, 149
— cord bladder and, xix, 156
— dilated ureter without stricture and, xix, 153
— obstruction in posterior urethra and, xix, 158
— ureteral duplication and, xix, 153
Chronic pyuria, classification of, xx, 14
— urinary findings in, xx, 15
Chronic rhinitis, classification of forms of, ix, 9
— simple, etiology of, ix, 9
— — symptoms of, ix, 10
— — treatment of, ix, 10
Chronic sepsis, blood-picture of, xi, 76
Chronic synovitis, vii, 83
Chronic tenosynovitis, vii, 263
Chronic tetanus, xv, 10
Chronic thecitis, vii, 263
Chronic tonsillitis, character of cough of, ix, 99
— etiology of, ix, 57
— pathology of, ix, 57
— symptoms of, ix, 58
— treatment of, ix, 60
Chronic traumatic arthritis, characteristics of, vi, 123
Chronic tuberculous peritonitis, xv, 303
Chronic tuberculous pneumonia, diagnosis of, ix, 241
Chronic ulcerative colitis, descriptive summary of, viii, 198
— etiology of, viii, 198
— lesions of, viii, 199
— operative management of, viii, 202
— symptoms of, viii, 199

Chronic ulcerative colitis, treatment of, viii, 201
Chronic ulcerative tuberculosis of lung, ix, 241
Chronological schema for infancy, iv, 200
Chrysarobin, dermatitis caused by, xvi, 42
Chvosteck's sign, age incidence of, v, 134
— alkalosis and, xx, 174
— rickets and, vii, 186, 195
— spasmophilia and, x, 251
— tetany and, v, 10, 131, 135; x, 251; xiii, 34
Chyluria, etiology of, xix, 67
— significance of, xx, 12
Cicatrix, etiology of, xvi, 317
— pathology of, xvi, 317
— symptoms of, xvi, 317
— treatment of, xvi, 318
Cimex lectularius, iii, 348; xvi, 157
Cingulum, xvi, 87
Circulation, anatomy of fetal, ii, 54
— cerebrospinal, v, 5, 111
— disturbances of, lactic acid acidosis and, xx, 171
— newborn, i, 136
— physiology of, ii, 53
— pregnancy and, i, 30, 162
— time of, ii, 56
Circulatory collapse, adrenalin for, ix, 266
Circulatory diseases, advanced, heliotherapy contraindicated in, ix, 260
Circulatory disturbances of skin, xvi, 56
Circumcision, ii, 133
— hygienic value of, xix, 215
— newborn, iii, 261
— — diphtheria following, iii, 25
— technic of, xv, 353
Circumscribed edema, acute, xvi, 76
Circus movement, pathological physiology of, xviii, 49
Cirrhosis, hepatic, etiology of, viii, 330
— "pericellular," congenital syphilis causing, iii, 58
Cirsoid aneurysm, xv, 157
Cisterna magna, anatomy of, v, 111
— puncture of, v, 87
— — dangers of, v, 93
— — technic of, v, 91; xx, 96
Citrated blood, hemorrhagic disease and, ii, 240
Citrous fruits, scurvy prevented by use of, x, 219
Civic maternity protection campaigns, i, 155
Clavicle, congenital absence of, vii, 49
— fracture of, birth, i, 121, 127; iii, 296; xv, 74
— — diagnosis of, vi, 165
— — frequency of, vi, 161
— — prognosis of, vi, 165
— — symptoms of, vi, 164
— — treatment of, i, 123; vi, 165; xv, 82
— — x-ray examination of, vi, 165
Clavus, etiology of, xvi, 33
— treatment of, xvi, 324
Claw-foot, hereditary ataxias causing, v, 70
Claw-hand, peripheral nerve injury and, vi, 253
Claw-toes, acute infectious arthritis causing, vi, 58
Cleft lip, congenital, embryology of, xv, 166
— — etiology of, xv, 167
— — treatment of, xv, 168
— breast milk supply limited by, iii, 134
-- disfiguration from, viii, 6
— effect upon health, viii, 7
— embryology of, xv, 166
— etiology of, iii, 131; vii, 54; xv, 167
— feeding problems in, iii, 134
— hereditary syphilis and, i, 67
— malnutrition and, iv, 152
— nursing and, iv, 48
— nutritional care in, vii, 54
— occurrence of, viii, 6
— pathology of, iii, 131
— prognosis of, viii, 10
— spina bifida associated with, vii, 48
— symptoms of, iii, 133
— treatment of, iii, 133; vii, 55; viii, 10; xv, 168
— when to operate on, viii, 8

Climate, accessory nasal sinus disease and, ix, 36
— adenoids and, ix, 68
— asthma and, ix, 111
— bronchopneumonia and, ix, 136
— chronic bronchitis and, ix, 108
— chronic rhinitis and, ix, 12
— chronic tonsillitis and, ix, 57
— nasal infections and, ix, 3
— pollen fevers and, ix, 119
— rheumatic heart disease and, xviii, 6
— tuberculosis and, ix, 221
Clinical examination, history in surgical cases, xv, 3
— physical examination, xv, 4
Clinics, gynecologic, public health and, i, 158
— obstetrical, need for, i, 150
— pediatric, Public Health and, i, 158
— prenatal, i, 10-13; ii, 2
— — child hygiene and, v, 176
— — doctors' duties at, i, 160
— — maternity protection and, i, 156
— — midwifery and, i, 154
— — stillbirth observations in i, 8
— — Wassermann reaction reports in, i, 77
— preschool children and, iv, 179
— summer, child hygiene and, iv, 170
Clitoris, adherent prepuce of, xv, 355
— anomalies and malformations of, iii, 263
— embryology of, xix, 6
Cloaca, embryological considerations of, xix, 8
Clonus, encephalitis and, v, 101
— interpretation of, v, 11
Closed circuit metabolism apparatus, xiii, 1, 4
Clothing, art of infant feeding and, xii, 144
— baby, i, 171
— hygiene and, iv, 87
— infant, iv, 87
— layette, ii, 127
— maternity, i, 162-164
— preschool age, iv, 87
— school age, iv, 87
Clotting, blood, character of, xx, 38
— — newborn, i, 120, 138
— — head injuries and, i, 113
Clotting, blood platelets and, ii, 233
— cerebrospinal fluid, v, 16
— scheme of, ii, 232
Cloudy swelling, nephrosis and, xix, 78
Clubbed fingers, congenital cyanosis and, ii, 204
Club-foot, congenital, iii, 287; vii, 280
— — description of, vi, 280
— — diagnosis of, vi, 281
— — hydrocephalus and, vii, 54
— — prognosis of, vi, 281
— — spina bifida associated with, vii, 48
— — spina bifida occulta and, v, 52
— — treatment of, vi, 282
— — varieties of, vii, 61
Club-hand, iii, 287; vi, 278
— absence of radius causing, vii, 56
Clutton's joints, hereditary syphilis differentiated from, xvii, 247
Coagulable lymph, xi, 2
Coagulation, platelets and, xi, 6
— ultraviolet rays and, x, 26
Coagulation time, calcium lactate and, ix, 73
— determination of, xi, 28
— newborn blood, ii, 65; xx, 36
— — blood platelets and, ii, 233
— — hemorrhagic diseases and, ii, 237
— — method for testing, ii, 237
— — scheme of, ii, 232
Coal tar paste, formula of, xvi, 347
Coarctation of aorta, xviii, 145
Cocain, acute rhinitis and, ix, 7
— pollen fevers and, ix, 119
— traumatic rhinitis and, ix, 17
Cocci, pyrogenic, skin diseases due to, xvi, 203
Coccygeal fistula, iii, 309
Coccyx, tumors of, surgery of, xv, 215, 216
Cocoa, diet of pregnancy and, i, 23
Codein, bronchopneumonia and, ix, 135
— pleurisy and, ix, 194
— pleurisy with effusion and, ix, 198
— therapeutic use of, respiratory diseases and, ix, 264
Cod-liver oil, acute bronchitis and, ix, 105

Cod-liver oil, acute rhinitis and, ix, 9
— administration of, iv, 123
— arthritis deformans and, vii, 107
— artificial feeding and, ii, 159
— atrophic rhinitis and, ix, 14
— chronic bronchitis and, ix, 109
— chronic pneumonia and, ix, 170
— chronic rhinitis and, ix, 12
— enlarged non-tuberculous bronchial glands and, ix, 211
— infant feeding and, i, 146
— joint tuberculosis and, vi, 72
— osteomalacia and, xiii, 166
— premature infants and, ii, 186; xii, 105
— rickets and, x, 232, 233, 244; xiii, 119
— rickets prevented by Vitamin "D" in, iv, 122
— tetany and sasmophilia and, v, 135; x, 252
— tonic use of, respiratory diseases and, ix, 267
— vitamin content of, x, 22, 24
Coefficient, urea, ii, 103
Coffee, diet of pregnancy and, i, 23, 165
— heart disease contraindicating, i, 32
Cohabitation, pregnancy and, i, 20, 45, 95
Cold, chest, ix, 101
— counterirritant use of, respiratory diseases and, ix, 257
— dermatitis caused by, xvi, 33, 36
— head, ix, 1
— — tonsillectomy and, ix, 60
— prophylactic immunization of, iv, 132
— sensation present at birth, ii, 115
Cold abscess, spinal pressure caused by, v, 123
— tuberculous, xvi, 233
— — multiple abscesses of infants differentiated from, xvi, 219
Cold hemoglobinuria, xix, 68
Cold pack, therapeutic use of, respiratory diseases and, ix, 259
Cold sore, xvi, 84
Cold sponge bath, therapeutic use of, respiratory diseases and, ix, 259
Colic, infantile air swallowing and, xii, 114
— — breast feeding and, i, 145; ii, 148
— — general considerations of, iii, 177
— — manifestations of, viii, 99
— — treatment of, iii, 178; viii, 99
— — types of, viii, 98
Colic intussusception, xv, 314
Colicystitis, xix, 138
Colitis, chronic ulcerative, descriptive summary of, viii, 198
— — etiology of, viii, 198
— — lesions of, viii, 199
— — operative management of, viii, 202
— — symptoms of, viii, 199
— — treatment of, viii, 201
Collapse, delivery and, i, 131
Colles' fracture, infancy and, xv, 95
— rarity in young children, vi, 151
Colles' law, i, 66
— feeding of syphilitic infant and, iii, 57
— hereditary syphilis and, iii, 39; xvii, 10
— paternal germ transmission of syphilis and, xvii, 64
Colloidal benzoin reaction, xx, 100
Colloidal gold reaction, neurosyphilis and, xvii, 55
Colloidal silver, newborn rhinitis and, iii, 78
Colloids, tissue, edema and, xix, 76
Coloboma, iii, 355, 357
Colon, bacillus infections of, bacteremia and, i, 94
— — pyelitis of pregnancy and, i, 34, 35, 36
— — puerperal, i, 88, 89
— congenital dilatation and hypertrophy of, viii, 239
— congenital idiopathic dilatation of, growth and prognosis of, xv, 2, 322
— Hirschsprung's disease of, viii, 239
— irrigations of, eclampsia and, i, 39
— — nausea and, i, 25
— — pyelitis and, i, 34
— — toxemias and, i, 36

Colon, newborn, abnormalities of position of, iii, 155
— — anatomy of, iii, 127
— — atresia of, iii, 145
— — stenosis of, iii, 145
— small, viii, 245
Colon bacillus meningitis, cerebrospinal fluid in, xx, 112
Colon irrigations, method of therapeutic use of, respiratory diseases and, ix, 267
Colonic lavage, colic and, iii, 178
Color, cerebrospinal fluid, v, 14
— hair, heredity and, iv, 8
Color-blindness, heredity and, iv, 8
Color index of blood, xx, 31, 33
— in newborn, ii, 65
Colored race, incidence of syphilis in, xvii, 89
— neurosyphilis in, incidence of, xvii, 175
Colored women, pregnant, syphilis among, i, 77
Colostrum, caloric value of, ii, 144
— composition of, ii, 144; xii, 160; xx, 120
— corpuscles of, ii, 144
— englobulin of, ii, 73, 90
— immunity and, ii, 144; iii, 8
— laxative effect of, ii, 144
— respiratory quotient affected by, ii, 96
Coma, acidosis cases after labor and, i, 131
— diabetic, xiii, 102
Comedo, xvi, 279
Commercial pasteurization, unreliability of, xii, 18
Communicable diseases, immunity conferred by, iv, 128
— prevention of, iv, 128
— variation in virulence of, iv, 129
Community maternity protection, i, 155
— hospitals and, i, 159
— midwifery and, i, 154
— prenatal care and, i, 11
Compatibility tests, transfusion and, ii, 73
Compensation, broken, prevention of, iv, 127
Compensatory lumbar lordosis, vi, 17, 19
Complemental feeding, iv, 49
— breast feeding and, xii, 176
— indications for, ii, 155
— prematurity and, ii, 185
— simple formula for, iv, 50
Complete heart-block, diagnosis of, xviii, 200
— electrocardiographic determination of, xviii, 175
Compound fractures, infancy and, xv, 116
Compressibility of vertebral column, v, 22
Concentrated foods, cereal milk and, xii, 38
Concentration test, diet in, xix, 41
— kidney function and, xix, 39; xx, 21
Conception, familial syphilis and, xvii, 96
— frequency of, health and, i, 6
Conceptional syphilis, i, 65, 66
Condensed milk, growth and development and, xii, 17
— sweetened, composition of, xii, 34
Conduction derangement, electrocardiographic determination of, xviii, 172
Condyloma, acquired syphilis and, xvii, 240
— congenital syphilis and, iii, 43
— gonorrheal, ferric chlorid in, i, 61
— inherited syphilis causing, xvii, 113, 128, 247
Condyloma acuminatum, xvi, 319
Confinement shelters, civic, i, 157
Conflicts, psychological, preventive pediatrics and, iv, 69
Confluent variola, xiv, 90
Congenital abnormalities, adenoma sebaceum, xvi, 22
— epidermolysis bullosa, xvi, 18
— ichthyosis, xvi, 13
— keratosis palmaris et plantaris, xvi, 17
— multiple benign cystic epithelioma, xvi, 27
— neurofibromatosis, xvi, 25
— nevi, xvi, 1
— Recklinghausen's disease, xvi, 25

Congenital abnormalities, syringocystoma, xvi, 28
— urticaria pigmentosa, xvi, 28
— xeroderma pigmentosum, xvi, 19
Congenital acholuric jaundice, xi, 5
Congenital acro-asphyxia, ii, 196
Congenital alopecia, iii, 350; xvi, 252
Congenital alopecia areata, iii, 350
Congenital amyotonia, iii, 248; v, 213
Congenital anomalies, v, 50
— acrocephaly, v, 52
— anomalies of spine, vi, 292
— classification of, vi, 274
— deformities of feet, vi, 280
— deformities of hip, vi, 288
— deformities of knee, vi, 287
— diagnosis a lazy one, v, 41
— ectapic testis, xix, 211
— encephalocele, v, 50
— epispadias, xix, 214
— etiology of, vi, 274
— hydrocele, xix, 212
— hypospadias, xix, 213
— malnutrition and, iv, 152
— meningocele, v, 50, 56
— multiple anomalies, v, 55
— narrowing of meatus, xix, 215
— obstruction of urethra, xix, 215
— orthopedic management and, vi, 49, 274
— paraphimosis, xix, 214
— phimosis, xix, 214
— rarity of, v, 9
— scaphocephaly, v, 52
— skull defects, v, 50
— spinal column defects, v, 50
— structural, v, 187
— torticollis, vi, 292
Congenital aphakia, iii, 356
Congenital asphyxia, ii, 190
— symptoms of, ii, 193
Congenital atresia of bile-ducts, jaundice and, xv, 330
Congenital atrophy orthopedics and, vi, 274
Congenital bile-duct obliteration, iii, 201
Congenital blindness, iii, 356
Congenital bone deficiencies, chondrodysplasia fœtalis, vi, 192
— dyschondroplasia, vi, 192
Congenital bone deficiencies, fragilitas ossium, vi, 189
— osteosclerosis, vi, 191
Congenital bronchiectosis, iii, 92
Congenital calcaneovalgus, treatment of, vi, 286
Congenital cardiac disease, malnutrition and, iv, 152
Congenital cataract, iii, 356
Congenital cleft lip, embryology of, xv, 166
— etiology of, xv, 167
— treatment of, xv, 168
Congenital cleft-palate, embryology of, xv, 166
— etiology of, xv, 167
— treatment of, xv, 168
Congenital club-foot, description of, vi, 280
— diagnosis of, vi, 281
— prognosis of, vi, 281
— treatment of, vi, 282
Congenital cutaneous defects, iii, 316
Congenital cyanosis, ii, 204
Congenital cystic hygromata, surgical aspects of, xv, 63
Congenital cystic kidney, iii, 267
— development of, xix, 3
— symptoms of, xix, 12
— Wilms' tumor differentiated from, xix, 186
Congenital dacryocystitis, iii, 360
Congenital debility, breast feeding and, ii, 154
— deaths during first 14 days, ii, 5
— hernia and, iii, 160
— incubators and, ii, 179
— infant mortality and, iv, 111
— malnutrition caused by, iv, 151
— medicinal treatment of, ii, 186
— mortality due to, ii, 4
— prematurity and, ii, 160, 171
— relaxed position in, ii, 12
— treatment of, ii, 186
Congenital defect of heart, electrocardiographic determination of, xviii, 184
Congenital` deformity, body proportions and, ii, 30
Congenital diaphragmatic hernia, classes of, iii, 161

Congenital diaphragmatic hernia, diagnosis of, iii, 163
— pathology of, iii, 162
— symptoms of, iii, 162
— treatment of, iii, 164
Congenital dilatation and hypertrophy of colon (Hirschsprung's disease), viii, 239
Congenital diseases, infant death and, i, 8
Congenital dislocations, iii, 288
Congenital equinus, treatment of, vi, 286
Congenital esophageal atresia, cause of, iii, 137
— clinical picture of, iii, 137
— diagnosis of, iii, 138
— general considerations of, iii, 135
— treatment of, iii, 139
Congenital esophageal malformation, viii, 72
Congenital flatfoot, treatment of, vi, 286
Congenital floating kidney, iii, 265
Congenital fractures, vi, 175
Congenital glaucoma, iii, 357
Congenital goiter, iii, 382
Congenital heart-block, iii, 110
Congenital heart disease, cardiac signs of, iii, 113
— cause of, iii, 103
— diagnosis of, iii, 115
— general signs and symptoms of, iii, 113
— mongolism and, xiii, 157
— prognosis of, iii, 116
— treatment of, iii, 117
— unpreventability of, iv, 126
Congenital hematuria, xix, 70
Congenital hepatic malformation, iii, 199
Congenital hip dislocation, vi, 288
Congenital hydronephrosis, iii, 267
Congenital hypertrophic pyloric stenosis, clinical features of, xv, 285
— diagnosis of, xv, 288
— incidence of, xv, 283
— operative results of, xv, 296
— operative treatment of, xv, 292
— treatment of, xv, 290
Congenital hypertrophy, iii, 311; vi, 274
Congenital icterus, iii, 200
Congenital idiopathic dilatation of colon, growth and prognosis of, xv, 2, 322
Congenital interstitial encephalitis, iii, 245
Congenital intestinal diverticula, treatment of, xv, 280
Congenital jaw anomalies, iii, 130
Congenital kidney anomalies, xv, 364
Congenital kyphosis, iii, 282
Congenital laryngeal abnormalities, ix, 75
Congenital laxity, knee showing, vi, 13
Congenital leukoderma, iii, 345
Congenital lingual anomalies, iii, 130, 193
Congenital lordosis, iii, 282
Congenital malformations, infant mortality and, iv, 111
— heart, xviii, 129
— tumors of back and, xv, 206
Congenital megacolon, character of stools in, xx, 73
— characteristics of, viii, 239
Congenital microcolon, viii, 245
Congenital myotonia, iii, 248
Congenital myxedema, iii, 380
— clinical features of, xv, 120
— treatment of, xv, 121
Congenital nephritis, iii, 273
Congenital nystagmus, v, 58
Congenital osteosclerosis, vi, 191
Congenital pachyonychia, xvi, 266
Congenital peritonitis, iii, 206
Congenital pyloric stenosis, viii, 113
— cause of, iii, 139
— diagnosis of, iii, 142
— pathology of, iii, 140
— prognosis of, iii, 143
— symptoms of, iii, 140; xii, 115, 189
— treatment of, iii, 143
Congenital rickets, iii, 306
Congenital sacral tumors, iii, 309
Congenital sacrococcygeal sinuses and fistulæ, surgery of, xv, 217
Congenital scapular elevation, iii, 283
Congenital scoliosis, iii, 281
Congenital stenosis of meatus, xv, 354

Congenital stridor, cause of, iii, 72
Congenital sublingual cyst, iii, 193
Congenital syphilis, acquired syphilis distinguished from, iii, 38
— bone lesions in, i, 63, 70-73, 76; iii, 44; vi, 98
— cause of, iii, 39
— clinical cures in, prognosis of, xvii, 253
— clinical history of, iii, 40
— Colles' law and, iii, 39
— criteria of cure in, xvii, 256
— definition of, xvii, 1
— dermatitis gangrenosa infantum differentiated from, xvi, 222
— diagnosis of, iii, 51
— — clinical manifestations in, xvii, 242
— — laboratory tests in, xvii, 242
— differential diagnosis of, iii, 52
— drugs used in treatment of, xvii, 259
— dwarfism and, xiii, 153
— ear conditions due to, i, 76
— early, postmortem diagnosis of, xvii, 33
— eczema seborrheicum differentiated from, xvi, 137
— eye conditions due to, i, 76
— feeding and, iii, 57
— frequency of, iii, 39
— hemorrhagic diseases of newborn and, ii, 231
— hydrocele and, iii, 49
— infant deaths due to, i, 64, 65, 77
— late, pathological evidence of, xvii, 33
— liver enlargement in, iii, 48
— meningitis and, iii, 49
— microscopic findings in, iii, 49
— nasal manifestations of, ix, 15
— pathology of, iii, 58; xvii, 20
— pemphigus neonatorum differentiated from, xvi, 213
— pemphigus vulgaris differentiated from bullous lesions of, xvi, 101
— periostitis of, scurvy differentiated from, xiii, 125
— placenta and, iii, 50
— pneumonia alba in, iii, 88
Congenital syphilis, prenatal care and, i, 14
— prognosis of, factors influencing, xvii, 251
— prophylaxis of, iii, 53; xvii, 258
— pseudoparalysis of Parrot and, iii, 44
— scurvy differentiated from, viii, 211
— serological investigation of, xx, 68
— skin manifestations of, iii, 42
— spastic cerebral paralysis and, vi, 238
— spleen pathology in, iii, 58
— splenomegaly in, iii, 48
— spontaneous recovery in, prognosis of, xvii, 254
— stigmata of, xvii, 39
— surgical aspects of, xv, 46
— symptomatic treatment of, iii, 57
— symptoms of, iii, 41
— teeth conditions due to, i, 76
— test for, living child, i, 78
— treatment of, i, 81, 83; iii, 53; xvii, 258
— — outline for, xvii, 268
— — results of, iii, 57; xvii, 281
— — special methods of, xvii, 266
— Wassermann reaction in, iii, 50
— x-ray findings in, iii, 46
Congenital talipes equinovarus, vii, 280
Congenital tongue-tie, treatment of, xv, 174
Congenital torticollis, iii, 311
Congenital umbilical hernia, iii, 156
— liver and, iii, 199
Congenital valgus, treatment of, vi, 286
Congenital varicose veins, iii, 112
Congenital volvulus, treatment of, viii, 237; xv, 280
Congestion, cerebral, newborn, i, 137
— pelvic, abortion causing, i, 6
Congestive heart-failure, rheumatic infection and, xviii, 86
Conjunctiva, anomalies of, iii, 360
— icterus neonatorum and signs in, ii, 217
— pollen fevers and, ix, 118
Conjunctival diphtheria, xiv, 165
Conjunctival reflex, ii, 114

Conjunctivitis, cerebrospinal meningitis complicated by, xiv, 283
— gonorrheal, xx, 93
— isolation of newborn with, ii, 137
Conservation, child life, i, 6, 12, 15, 150-175
Constipation, artificially fed infant and, viii, 223
— atresia of small intestine causing, iii, 148
— breast-fed infant and, viii, 221
— broths indicated in, xii, 133
— chronic, character of stools in, xx, 73
— — diagnosis of, viii, 229
— — etiology of, viii, 226
— — older children and, viii, 226
— — symptoms of, viii, 229
— — treatment of, viii, 230
— convulsions and, v, 137
— dentition and, xii, 136
— diet and, xii, 126
— dried cereals causing, xii, 132
— fat indigestion and, xii, 45, 78, 84
— general considerations of, iii, 179
— habitual, hygiene and, iv, 90
— Hirschsprung's disease and, viii, 241
— hypertrophic pyloric stenosis and, viii, 116
— vomiting caused by, xii, 114
— intestinal indigestion and, xii, 125
— malnutrition and, iv, 161
— milk diet causing, xii, 126
— newborn and, viii, 221
— nursing and, xii, 189
— peptonized milk and, xii, 22
— posture and, iv, 35
— pregnancy and, i, 22, 25
— — treatment of, i, 166
— prophylaxis of, xii, 126
— rickets causing, x, 240
— spasmodic laryngitis and, ix, 79
— treatment of, viii, 222, 224
— vegetables and, xii, 134
Constitution, malnutrition and, iv, 152, 161
Constitutionally inferior child, nutritional characteristics of, xii, 5
Constriction, bandage, symptoms of, vi, 45
Consumption, early use of the term, ix, 216
Contagion, puerperal fever and, i, 86
Contagious impetigo, xvi, 204
Contractions, electrical, interpretation of, v, 134
— hunger, newborn, ii, 85
— tetany showing, v, 132
Contractures, alcohol injections for relief of, v, 145
— brachial paralysis causing, v, 29
— operations for relief of, v, 144
— relief by reduction of nerve supply, v, 145
— scar, etiology of, vi, 201
— — factors determining extent of, vi, 201
— — prevention of, vi, 202
— — treatment of, vi, 204
— Stoeffel operation for relief of, v, 145
— Volkmann's, vii, 239
— — management of, vii, 159; vi, 211
Contraindications for nursing, iv, 48
Contusio cerebri, iii, 224
Contusions, abdominal, significance of, xv, 296
— — treatment of, xv, 297
Conus pulmonalis, stenosis of, xviii, 134
Convalescence, importance of mental efficiency during, v, 174
— postnatal, i, 160
Convalescent homes, care of heart disease in, xviii, 234
Convalescent serum, chickenpox and, iv, 138
— erysipelas and, iii, 20
— infantile paralysis and, v, 105
— measles and, iv, 137
— measles in newborn and, iii, 28
— measles prophylaxis and, xiv, 54
— mumps and, iv, 141
— mumps immunity and, xiv, 151
— passive immunization with, iv, 130
— poliomyelitis therapy with, xiv, 248
Conversion table, avoirdupois and metric weights, x, 292
Convolutional atrophy, convulsions and, v, 137

Convulsions, acute follicular tonsillitis and, ix, 52
— alkalosis and, xx, 174
— allergy and, v, 137
— anemia of cortex causing, v, 128
— blood-sugar and, xx, 162
— bromides for control of, respiratory diseases and, ix, 264
— calcium content of blood in, v, 135
— cerebral palsy and, v, 150
— cerebrospinal fluid and, xx, 117
— cerebrospinal meningitis and, v, 137
— chronic pyelitis causing, xix, 161
— contractions in tetany, v, 131-132
— cortical anemia causing, v, 128
— diet and, v, 137
— endocrine factor in, v, 138
— epilepsy and, v, 138
— erysipelas causing, iii, 19
— "essential epilepsy," v, 128
— first month, v, 129
— general considerations of, iii, 246
— infantile, v, 130
— infection causing, v, 129
— "jacksonian," v, 136
— lactic acid acidosis following, xx, 172
— later infancy and childhood and, xii, 141
— lobar pneumonia and, ix, 146, 148
— meningitis and, v, 137
— nephritis and, v, 136
— neurosyphilis and, xvii, 186
— neurosyphilis clinically manifested by, xvii, 189
— newborn, v, 129
— — blood injections in, i, 116
— otitis media and, v, 137
— pneumonia causing, v, 78
— pregnancy and labor, acidosis and, i, 130
— — Dublin treatment of, i, 39
— — puerperal sepsis following, i, 92
— — shock and, i, 130
— — Stroganoff treatment of, i, 38
— prognosis in, v, 140
— pyknolepsy, v, 139
— respiratory factors, v, 138
— rickets and, vii, 196
— seriousness of, ii, 7
Convulsions, significance of, xv, 1
— suggestion and, v, 137
— tetany, v, 130; x, 249
— thymus enlargement and, v, 138
— toxemias and, i, 36, 38
— — fetal deaths in, i, 48
— — maternal deaths in, i, 4
— — prenatal care in, i, 10
— trauma causing, ii, 112
— treatment of, v, 139
— two years and after, v, 135
— whooping-cough causing, xiv, 125
— x-ray of skull and, v, 137
Coqueluche, synonyms of, xiv, 117
Cor biatriatum triloculare, iii, 105
Cor biloculare, iii, 105
Cor biventriculatum triloculare, iii, 105
Cord, spermatic, torsion of, xv, 271
— spinal, breech delivery and, iv, 8
— — hemorrhages of, i, 117, 120
— — icterus and, ii, 223
— — injuries of, birth, i, 117, 118, 137, 150
— — vertex delivery and, i, 117
— umbilical, abnormalities of, fetal death and, i, 48
— — bleeding, newborn, i, 138
— — clamping, i, 136
— — cyanosis caused by strangulation with, ii, 205
— — hernia into, xv, 256
— — ligation of, ii, 124
— — pyogenic infectoins of, fetal death and, i, 48
— — Wassermann reaction of, effect of treatment on, i, 78, 82
Cord bladder, chronic pyelitis and, xix, 156
Corectopia, iii, 362
Corn, etiology of, xvi, 33
— treatment of, xvi, 324
Cornea, anomalies of, iii, 361
— malformations of, iii, 357
— pollen fevers and, ix, 118
Corneal reflex, newborn, ii, 113
Coronary arteries, rheumatic infection of, pathology of, xviii, 38
Corpus luteum, milk secretion and, ii, 142

Corpus striatum, automatic associated movements and, v, 2
— effect of circulatory impairment of, v, 143
Corrective exercises, bear's walk, misplacements and, i, 19, 20, 161
— knee-chest position, i, 19, 35, 161
— monkey trot, i, 20, 161
— varicosities of vulva and, i, 168
Corrigan pulse, xviii, 120
— pregnancy and, i, 31
Corsets, dystrophies and use of, v, 66
— maternity, i, 162-164
Cortex, cerebral, convulsions caused by anemia of, v, 128
— — disorders affecting, v, 218
Cortical localization, v, 3
Corticospinal neurons, spasticity showing impairment of, v, 151
Corticospinal tracts, muscle tone and disease of, v, 1
— spasticity following injury of, v, 49
Corynebacterium diphtheriæ, xiv, 154, 158
Coryza, allergic, ix, 117
— Chronic, ix, 9
— — syphilis causing, iii, 52
— definition of, ix, 1
— syphilitic, ix, 15
Cost of digestion, protein, xiii, 16
— use of the term, xiii, 3
Cotton, clothing for infant made from, ii, 128
Cough, accessory nasal sinus disease and, ix, 29
— adenoids causing, ix, 71
— bronchopneumonia and, ix, 128
— causes of, ix, 98
— croupous, character of, ix, 80
— diphtheria antitoxin and, ix, 79
— enlarged non-tuberculous bronchial glands and, ix, 206
— extrarespiratory causes of, ix, 100
— foreign bodies causing, ix, 188
— iodids for, ix, 79
— lobar pneumonia, ix, 144
— tonsillectomy and, ix, 60
— tuberculosis and, ix, 228
Counterirritants, respiratory diseases and, ix, 256
Cowpox, blood-count in, xi, 47
— synonyms of, xiv, 104
Cow's milk, bacteriology of, xx, 121
— composition of, xii, 10, 11, 166; xx, 121
— tuberculous infection and, xii, 12
Coxa plana, diagnosis of, vi, 110
— etiology of, vi, 108
— prognosis of, vi, 110
— symptoms of, vi, 109
— treatment of, vi, 110
— tuberculosis of joints differentiated from, vi, 71, 83
— x-ray examination, vi, 110
Coxa valga, etiology of, vi, 114
Coxa vara, vii, 279
— diagnosis of, vi, 113
— epiphyseal separation causing, vi, 168
Coxalgia, differential diagnosis of, vii, 127
— prognosis of, vii, 127
— symptoms of, vii, 125
— treatment of, vii, 127
— etiology of, vi, 111
— hip-joint disease differentiated from, vii, 127
— pathology of, vi, 111
— prognosis of, vi, 113
— rickets causing, vi, 182
— symptoms of, vi, 112
— treatment of, vi, 113
— tuberculosis of joints differentiated from, vi, 83
— x-ray and, vi, 111
Coxitis, differential diagnosis of, vii, 127
— prognosis of, vii, 127
— symptoms of, vii, 125
— treatment of, vii, 127
Crab cellulitis, xvi, 215
Crabs, contraindicated in diet of pregnancy, i, 24
Cracked nipple, abscess resulting from, ii, 152
Crackers, caloric value of, x, 193
— chemical content of, x, 288
Cramps, abdominal, pregnancy and, i, 169
Cranial bones, fetal, calcium and, i, 139

Cranial bones, fetal, death due to overriding of, i, 50
Cranial nerves, examination of, v, 10
— latent syphilis and stigmata of, xvii, 226
— neurosyphilis and, xvii, 196
— syphilis of, pathology of, xvii, 39
Cranial pressure, deaths due to, i, 117
Craniorachischisis, anatomy of, vii, 53
Cranioschisis, anatomy of, vii, 53
Craniotabes, congenital rickets and, iii, 306
— rickets and, vii, 188; x, 236; xiii, 116
— syphilis and, vii, 142
Craniovertebral cavity, age affecting considerations of, v, 4
Craniovertebral infection, convulsions caused by, v, 129
Cranium, congenital defect of, iii, 280
Cream, bacterial content of, xii, 24
Cream and whey mixtures, xii, 26
Cream stridor, iii, 73
Creatin, amount in blood of newborn, ii, 78
Creatinin, amount of, ii, 78
— significance in blood, xx, 130
— urine containing, ii, 105
Credé expression of placenta, puerperal sepsis and, i, 91, 94, 97
Credé prophylactic treatment, ii, 125; iii, 366
Creeping eruption, xvi, 169
Cremasteric reflex, ii, 113, 115; v, 11
Creosote, inhalation of vapors of, chronic pneumonia and, ix, 170
— — lobar pneumonia and, ix, 166
— — respiratory diseases and, ix, 270
Crepitant râles, significance of, ix, 98
Crepitation, orthopedic significance of, knee and, vi, 13
Cretinism, body proportion typically abnormal in, ii, 30
— brain development in, x, 72
— clinical features of, xv, 120
— diagnosis of, xiii, 56
— dwarfism and, x, 138
— hypothyroidism differentiated from, xiii, 53
Cretinism, infantilism and, x, 140
— macroglossia in, iii, 130
— mentality and, v, 189
— mongolism differentiated from, xiii, 159
— newborn, iii, 380
— physical features of, v, 192
— prematurity and, ii, 171
— prognosis of, xiii, 59
— signs and symptoms of, xiii, 54
— thyroid feeding and, v, 172, 192
— treatment of, xiii, 61; xv, 121
Criminal tendencies, heredity and, v, 61
Crisis, lobar jneumonia and, ix, 155
Critical preëruptive fever, synonyms of, xiv, 320
Croup, ix, 79
— bronchial, ix, 106
— membranous, measles complicated by, xiv, 45
— spasmodic, diphtheria differentiated from, xiv, 168
— tonsillectomy and, ix, 60
Croupous laryngitis, ix, 79
Croupous pneumonia, ix, 137
Crusts, nasal, treatment of, ix, 14
Crutches, measurement for, vi, 28
Crying, hunger, i, 145
— metabolism and, xiii, 4
— newborn, i, 137
Cryocautery, xvi, 12
Cryptophthalmia, iii, 359
Cryptorchidism, etiology of, xix, 212
— management of, iii, 262
Crypts, Lieberkühn's, anatomy of, iii, 128
Crystals, urinary, xx, 18
Ctenocephalus canis and *felis*, xvi, 158
Culicidæ, iii, 348
Culture taking, method and indications for, respiratory diseases and, ix, 270
Cupping, dry, counterirritant use of, respiratory diseases and, ix, 258
Curdled milk, iv, 54
Curds, fecal, significance of, xx, 72
— human milk casein forming, xii, 163
— intestinal indigestion stools showing, xii, 120

Curds, soap-flake, ii, 93
Curettage, dangers of, abortion and, i, 47
— uterine, puerperal sepsis and, i, 104
Curiosity, development period of, x, 74
— preventive pediatrics and, iv, 70
Curschmann's spirals, asthma and, ix, 113
Cushing osteoplastic flap, head injuries and, birth, i, 113
Cutaneous sensations, newborn, ii, 115
Cutis marmorata, passive hyperemia and, xvi, 56
Cutis navel, iii, 400
Cyanosis, aspiration of pleuritic effusion indicated for, ix, 198
— bronchopneumonia and, ix, 129
— congenital, ii, 204
— — anoxemia in, ii, 204
— — atelectasis causing, ii, 165
— — causes of, ii, 203, 205
— — diagnosis, ii, 206
— — prematurity and, ii, 164, 165
— — prognosis of, ii, 207
— — seriousness of, ii, 7
— — symptoms of, ii, 172, 205
— — treatment of, ii, 207
— congenital heart disease and, iii, 113
— foreign bodies in respiratory tract causing, ix, 188
— heart failure and, i, 30; xviii, 50
— newborn, i, 138
— rheumatic infection and history of, xviii, 75
— Winckel's disease showing, iii, 2
Cyclic albuminuria, xx, 7
Cyclic vomiting, description of, viii, 134
— diagnosis of, viii, 136
— etiology of, viii, 134
— prognosis of, viii, 136
— symptoms of, viii, 135
— treatment of, viii, 137
Cyclopia, iii, 213, 355
Cylindroids, significance of, xx, 17
Cyst, bone, vi, 142; vii, 161; xv, 122
— brain, iii, 250
— bronchial, iii, 96
— — surgery of, xv, 183
— congenital sublingual, iii, 193
Cyst, dermoid, bronchial, xv, 184
— — sacrococcygeal, xv, 216
— echinococcic, xvi, 170
— — lung affected by, ix, 186
— enteric, treatment of, xv, 339
— facial, hemangioma and lymphangioma, xv, 173
— gliomatous, v, 120
— hepatic, iii, 201
— hydatid, lungs affected by, ix, 186
— lingual, viii, 6
— lymphatic, surgical aspects of, xv, 63
— mesenteric, treatment of, xv, 338
— omental, treatment of, xv, 338
— pulmonary, air-filled, ix, 187
— renal, xv, 364
— salivary, iii, 197
— scalp, xv, 156
— sebaceous, xvi, 282
— solitary renal, incidence of, xix, 13
— thymic, iii, 379
— thyroglossal, diagnosis of, xv, 185
— — treatment of, xv, 186
— thyroid, iii, 386
— tonsillar, ix, 66
— umbilical, xv, 282
— urachal, xv, 283; xix, 18
Cystic epitheliomata, multiple benign, xvi, 27
Cystic hygroma, iii, 97
— surgery of, xv, 197
Cystic kidney, congenital, iii, 267
— — development of, xix, 3
— — symptoms of, xix, 12
— — Wilms' tumor differentiated from, xix, 186
Cystic lymphangiomata, surgical aspects of, xv, 63
Cystic osteitis fibrosa, vi, 142
Cysticercus cellulosæ cutis, xvi, 170
Cystinuria, significance of, xx, 19
Cystitis, diagnosis of, xix, 208
— hematuria and, xix, 70
— incidence of, xix, 207
— symptoms of, xix, 207
Cystomata, pregnancy, i, 44
— — dermoid of the ovary, i, 44
— — operations on, i, 42, 44
— — vulvovaginal, i, 62

Cystoscopic examination, preparation of patient for, xix, 44, 168
Cystoscopy, xv, 349
Cytology of spinal fluid, xvii, 52
Cytorrhyctes variolæ, xiv, 83
Czerny-Kleinschmidt butter-flour mixtures, xii, 39

Dacryocystitis, congenital, iii, 360
— — syphilis causing, iii, 49
Dactylitis, congenital syphilis and, iii, 47
— inherited syphilis causing, xvii, 113, 136
— syphilitic, incidence of, xvii, 136
— tuberculous, vii, 132
— — syphilitic dactylitis, differentiated from, vii, 151
Dairy products, caloric value of, x, 192
— chemical composition of, x, 286
— vitamin content of, x, 285
Dakin's solution, acute osteomyelitis and, xv, 136
— burns and scalds and, xv, 20
— chronic empyema and, xv, 236
— scar prevention and, vi, 202
— skull fractures and, xv, 160
— suppurative pericarditis and, xv, 246
— wounds of soft parts and, xv, 8
Dandruff, synonyms of, xvi, 134
— treatment of, xvi, 135, 350
Danger signals, pregnancy, i, 168
Dangle-foot, vi, 223
Darier's disease, xvi, 309
Davis' skin grafts, scar contractures and, vi, 205
Day nurseries, prenatal care and, i, 156
Deaf-mutism, mumps and, xiv, 149
Deafness, adenoids and, ix, 71
— cerebrospinal meningitis causing, xiv, 293
— comparative at birth, ii, 115
— congenital syphilis, i, 76; iii, 49
— delayed speech due to, v, 195
— late inherited syphilis and, xvii, 166
— latent syphilis and, xvii, 226
— pollen fevers causing, ix, 118
Deafness, typhoid fever and, viii, 190
Death, age incidence of, iv, 105
— antenatal, prenatal care and, i, 8, 9
— — syphilis and, i, 63
— fetal, abruptio placentæ and, i, 55, 56
— — cardiac cases and, i, 33
— — causes of, i, 9, 48, 117
— — convulsions causing, i, 39
— — cranial pressure causing, i, 117
— — falx and tentorium rupture causing, i, 117
— — induction and, premature labor, i, 107, 108
— — in uterio, i, 48-50
— — labor complications causing, i, 111
— — maternal conditions causing, i, 9
— — midwives' responsibility for, i, 153
— — placental separation and, i, 55
— — prevention, prenatal care and, i, 9, 10
— — rates, i, 3, 4, 81, 82
— — syphilis causing, i, 63, 64; iv, 145
— infant, age rates, i, 7, 8
— — breast feeding and, i, 140
— — causes of, i, 7, 14, 140
— — early, causes of, i, 6, 7
— — enlarged thymus and, i, 138
— — factory day nurseries and, i, 156
— — falx and tentorium rupture causing, i, 117
— — hemorrhages causing, central nervous system, i, 118, 119, 120
— — prenatal care and, clinical reports of, i, 10-13
— — seasonal, i, 4
— — sepsis causing, i, 98
— — spinal injuries causing, i, 121
— — syphilis causing, i, 7, 64, 65, 77, 84
— — U. S. registration area, data for, iv, 108
— intranatal, i, 9
— intrapartum, birth injuries causing, i, 8
— intra-uterine, i, 48, 50, 107, 108
— maternal, acute yellow atrophy causing, syphilis and, i, 80

Death, maternal, anesthesia causing, acidosis and, i, 130, 131
— — asepsis and, i, 86
— — cesarian section and, i, 92
— — conception causing, frequency of, i, 6
— — eclampsia and, i, 39, 92
— — midwives' rseponsibility for, i, 153
— — milk leg and, i, 94
— — miscarriage and, i, 47
— — obstetrical technic and, i, 150
— — placenta and, manual removal of, sepsis in, i, 97
— — prenatal care and rate of, i, 10-13, 90
— — puerperal sepsis and, i, 4, 85, 90, 101, 104
— — rates, i, 2-5
— — sepsis and rate of, i, 98
— — shock at labor and, i, 130, 131
— — thrombophlebitis and, i, 104
— neonatal, i, 2, 8, 12, 63, 79, 111, 121
— newborn, causes during first 14 days, ii, 5
— postnatal, i, 9
— stillbirth, autopsy of, i, 9
— — breech deliveries and, i, 117
— — Census reports, i, 2
— — cerebral hemorrhage and, i, 112
— — frequency of conception and, i, 7
— — history of patient, i, 17
— — reduction of, prenatal care and, i, 10, 12, 81, 82, 84
— — spinal injuries and, i, 121
— — syphilis and, i, 63, 64, 77, 79, 81, 82, 84
— — traumatism at labor and, i, 111
Debility, congenital, breast feeding and, ii, 154
— — deaths during first 14 days, ii, 5
— — hernia and, iii, 160
— — incubators and, ii, 179
— — infant mortality and, iv, 111
— — malnutrition caused by, iv, 151
— — medicinal treatment of, ii, 186
— — mortality due to, ii, 4
— — prematurity and, ii, 160, 171
— — relaxed position in, ii, 12
— — sepsis neonatorum and, iii, 14
— — treatment of, ii, 186
Decapsulation, operation of, indications for, xix, 120
Decidua, colon bacillus infection causing, i, 89
Deciduous teeth, abnormalities of, viii, 63
— calcified at birth, iii, 124
— diseases of, viii, 63
— eruption of, iv, 32; viii, 60; x, 57, 75
— — disturbances during, viii, 62
— — vomiting and, viii, 94
— syphilitic stigmata of, xvii, 213
Decompensation, carditis and, xviii, 67, 88
— pregnancy and labor, treatment of, i, 32, 33
Decompression, cerebral, v, 146
Decubitus, etiology of, xvi, 33
Deep reflexes, v, 10
Defects, mental, epileptic, v, 211
— — intermediate, v, 209
— — moderate, v, 208
— — neurosyphilis and, xvii, 199
— — physical disability and, v, 210
— — severe, v, 209
— — types of, v, 208
Defective vision, malnutrition and, iv, 156
Deficiency diseases, acrodynia, xiii, 134
— beriberi, x, 264; xiii, 133
— endemic multiple neuritis, x, 264
— erythredema, xiii, 134
— erythredema polyneuritis, xiii, 134
— keratomalacia, xiii, 129
— pellagra, x, 254; xiii, 130
— pink disease, xiii, 134
— polyneuritis, x, 264; xiii, 133
— rickets, x, 229; xiii, 112
— scurvy, x, 218; xiii, 119, 121
— spasmophilia, x, 248
— tetany, x, 248
— xerophthalmia, xiii, 129
Defluvium capillitium, xvi, 256
Deformities, bone, acquired and developmental, vii, 274
— fetal death due to, i, 9
— foot, congenital, vi, 280
— — congenital club-foot, vi, 280
— — orthopedic management of, vi, 256

Deformities, foot, talipes, vi, 280
— hereditary syphilis and, i, 67
— hip-joint, congenital dislocation of, vi, 288
— knee, genu recurvatum, vi, 287
— — malformation and rotary displacements of, vi, 288
— spinal, hollow-back, vi, 269
— — round shoulders, vi, 269
— — scoleosis, vi, 260
— — spondylolisthesis, vi, 270
— static, hollow-back, vi, 269
— — orthopedic management of, vi, 256
— — round shoulders, vi, 269
— — scoliosis, vi, 260
— — spondylolisthesis, vi, 270
— — visceroptosis, vi, 272
— — weak foot, vi, 257
— structural, fetus and, i, 67
Degeneration, stigmata of, dental, xvii, 212
— — familial syphilis and, xvii, 106
— — latent syphilis and, xvii, 210
— — ocular, xvii, 210
Degenerative nephritis, blood chemistry in, xx, 151
— clinical features of, xx, 150
— conditions associated with, xx, 152
Deglutition pneumonia, ix, 176
Dehydration, body temperature and, ii, 109
— hemoglobin affected by, ii, 65
— newborn susceptibility and, iii, 7
— pathological physiology of, xiii, 40
— physical signs of, xv, 5
— results in body of, xx, 133
— size decrease due to, ii, 32
— transitory fever caused by, ii, 208
— treatment of, xv, 22
— viscosity affected by, ii, 65
— water requirements due to, x, 20
— weight decrease resulting from, ii, 38
Dehydration fever, ii, 208; x, 215; xiii, 40
— diagnosis of, ii, 211
— prognosis of, ii, 212
— temperature in, ii, 210
— treatment of, ii, 212
Delanginere bone-graft, ununited fractures and, vi, 175
Delayed speech, causes of, v, 195
Delayed tetanus, xiv, 300
Delinquency, relation of intelligence to, v, 155
Delivery, abruptio placentæ and, i, 56
— accidents at, i, 4, 7, 8, 9, 130-135
— acidosis at, i, 91, 130-133
— anesthesia during, i, 109, 169
— — convulsions in, i, 38
— — deaths with, acapnia and acidosis causing, i, 130, 131
— — infection caused by, i, 91
— — rectal, cardiac cases and i, 33
— — tuberculosis and, i, 29
— aseptic preparations at, i, 86, 95, 109
— blood-pressure during, shock and, i, 131
— bougie method at, i, 110
— breech, i, 8, 56, 60, 111, 117, 118, 121, 123, 131, 136
— — technic of, i, 128
— convulsions at, i, 4, 10, 36, 48, 116
— — treatment of, i, 38, 39
— dangers of, i, 150
— decompensation in treatment of, i, 32, 33
— dystocia in, i, 19, 41
— exhaustion at, breast milk and, i, 141
— forceps delivery, birth palsy in, i, 125
— — cardiac cases and, i, 32, 33
— — clavicular fracture in, i, 121
— — conservatism in, i, 19
— — convulsions after, i, 116
— — falx and tentorium ruptured in, i, 117
— — feeble-mindedness and, i, 111, 112
— — hematoma and, i, 125
— — hemorrhages in, bulbar and medullary, i, 120
— — lacerations and, i, 89
— — placenta prævia and, I, 60
— — skull injuries in, i, 116
— hemorrhage during, i, 91, 150
— — brain, newborn, i, 139

Delivery, hemorrhage during, central nervous system, death at birth and, i, 118, 119, 120
— — cerebral, newborn, i, 111, 112, 113, 137, 150
— — cerebrospinal, breech deliveries and, i, 117
— — dural, birth injuries and, i, 113
— — induction and, premature labor, i, 107
— — intracranial at birth, i, 111, 120
— history of patient and, i, 17
— hospital delivery, i, 5, 90, 157, 158, 162
— — sepsis in, i, 5, 90
— inertia and, i, 91
— infections during, i, 91, 86-105
— — abortion and, i, 6, 43, 47
— — bacteriology of, i, 87
— — blood transfusion and, i, 103, 104
— — Census reports of, i, 2
— — chemical treatment of, i, 104
— — eclampsia and, i, 92
— — endometritis and, i, 93
— — frequency of, i, 90
— — gonococcus causing, i, 61, 94
— — hygienic prevention of, i, 95, 96
— — leukocyte count in, i, 101
— — maternal deaths due to, i, 86
— — metritis and, i, 93
— — midwife's responsibility in, i, 153
— — miscarriage and, i, 47
— — mortality rates of, i, 90
— — operative treatment of, i, 91, 104
— — pathology of, i, 88
— — placental, i, 91, 94
— — predisposing causes of, i, 91
— — prenatal care and, i, 5, 12
— — protein therapy and, i, 103
— — serums in, i, 99-103
— — specific treatment of, i, 99
— — Staphylococcus aureus causing, i, 87
— — streptococcus causing, i, 87
— — symptomatology of, i, 93
— — thrombophlebitis and, i, 94
— — thrombosis and, i, 89
— — treatment of, i, 95-104
— injuries at, i, 111, 112
— — cephalic, i, 8, 112
— — clavicular, i, 121, 123, 127
Delivery, injuries at, extremities and, i, 121
— — infant death due to, i, 7, 8
— — intrapartum, i, 111-129
— — nerves and, i, 124
— — obstetrical management and, i, 8
— — spinal, i, 117
— instructions, i, 95, 169
— lacerations at, i, 45, 88, 91
— — repair of, i, 89, 97
— mania at, acute, i, 40
— midwife's service at, i, 151-154
— operative delivery, i, 91, 104
— — death from sepsis in, i, 90, 91
— — dystocia and, i, 19
— — inertia necessitating, i, 91
— — infections following, i, 87, 90, 91, 104
— — injuries in, i, 111, 128
— — pelvic examination and, i, 19
— — shock prevention and, i, 19
— pains at, i, 109, 169
— — abruptio placentæ and, i, 54, 55
— — acute cystoma and, i, 42
— — breast feeding and, i, 140
— — fibromyomata and, i, 44
— — heart, i, 30, 31
— — lower back, i, 169
— — neuralgic, toxemias and, i, 37
— — premature imitation of, i, 109
— — prenatal care and, i, 45
— pelvic measurements at, i, 18
— placenta prævia and, i, 60
— premature, cardiac cases and, i, 33
— — conservatism and, i, 19
— — death in utero prevented by, i, 49
— — induction of, i, 106-110
— — prenatal care preventing, i, 12, 15, 149
— — syphilis causing, i, 79
— — uterine myomata and, i, 42
— prenatal care and, i, 12, 15, 149
— Public Health measures, protection of mother and child and, i, 150-175
— rubber bags and, i, 108
— sepsis causing deaths at, i, 4
— shock following accidents of, i, 130-135

Delivery, shock following accidents of, primary, i, 131
— — secondary, i, 133
— shoulder delivery, i, 121, 122, 123, 128
— — fractures in, i, 127
— — subluxation in, birth palsy due to, i, 124
— — technic of, i, 128
— stillbirths at, autopsy of, i, 9
— — breech deliveries and, i, 117
— — causes of, i, 8
— — Census reports of, i, 2
— — cerebral hemorrhage and, i, 112
— — frequency of conception and, i, 6
— — history of patient and, i, 17
— — reduction of, prenatal care and, i, 10, 12, 81, 82, 84
— — spinal injuries and, i, 121
— — syphilis and, i, 63, 64, 77, 79, 84
— — tears and, falx and tentorium, i, 117
— — traumatism and, i, 111
— supplies for, i, 170
— tamponage in, i, 110
— toxemia and, i, 131
— tuberculosis and, i, 29
— tumors at, i, 18, 41-44, 45
— uterine myomata and, i, 42
— version, i, 120, 121, 131
— — abortion and, i, 43
— — Braxton-Hicks, placenta prævia and, i, 60
— — cardiac cases and, i, 33
— — collapse in, i, 131
— — conservatism and, i, 19
— — decompensation and, i, 32
— — internal podalic, placenta prævia and, i, 60
— — spinal injuries, i, 120, 121
— vertex, i, 117, 121
— Wassermann reaction at, i, 76
Dementia, syphilitic, neurosyphilis and, xvii, 199
Demodex folliculorum, xvi, 168
Dengue, blood-count in, xi, 47
Dental hygiene, importance of, viii, 69
— permanent teeth and, viii, 71
— prenatal care and, viii, 70
Dental hygiene, preschool child and, viii, 70
Dental paralysis, synonyms of, xiv, 224
Dental pulp, gangrenous inflammation of, iii, 191
Dental stigmata, syphilitic, xvii, 212
Dentio præcox, iii, 130
Dentistry, pregnancy and, i, 166
Dentition, deciduous, viii, 60
— — abnormalities of, viii, 63
— eczema and, xvi, 116
— feeding and, xii, 136
— nutrition indicated by, x, 106
— permanent, viii, 65
— — abnormalities of, viii, 65
Depigmentation, types of, xvi, 288
Depression, mental, pregnancy and, i, 39, 169
— skull, iii, 290
Dermanyssus gallinæ, xvi, 159
Dermatitis, ammoniacal, hereditary syphilitic lesions differentiated from, xvii, 244
— artificial, classification of, xvi, 33
— exfoliative, arsphenamin injections causing, xvii, 274, 277
— — newborn, syphilitic pemphigus confused with, i, 75
— uncinarial, xvi, 171
Dermatitis actinica, xvi, 36
Dermatitis calorica, xvi, 36
Dermatitis exfoliativa neonatorum, iii, 323
— diagnosis of, xvi, 308
— etiology of, xvi, 308
— prognosis of, xvi, 309
— symptoms of, xvi, 307
— treatment of, xvi, 308
Dermatitis factitia, xvi, 54
Dermatitis gangrenosa infantum, diagnosis of, xvi, 222
— etiology of, xvi, 222
— pathology of, xvi, 222
— prognosis of, xvi, 223
— symptoms of, xvi, 222
— treatment of, xvi, 222
Dermatitis herpetiformis, diagnosis of, xvi, 105
— erythema multiforme differentiated from, xvi, 62

Dermatitis herpetiformis, etiology of, xvi, 104
— history of, xvi, 102
— hydroa vacciniforme differentiated from, xvi, 97
— nails affected in, xvi, 269
— pathology of, xvi, 104
— prognosis of, xvi, 106
— symptoms of, xvi, 102
— treatment of, xvi, 105
— urticaria differentiated from, xvi, 75
Dermatitis medicamentosa, iii, 322
— diagnosis of, xvi, 47
— etiology of, xvi, 47
— symptoms of, xvi, 47
— treatment of, xvi, 48
Dermatitis traumatica, diagnosis of, xvi, 34, 35
— symptoms of, xvi, 34, 35
— treatment of, xvi, 34, 36
Dermatitis vegetans, xvi, 220
Dermatitis venanata, etiology of, xvi, 41
Dermatomyositis, vii, 234
Dermatophytosis, treatment of, xvi, 349
Dermatothlasis, xvi, 256
Dermographism, urticaria and, xvi, 29, 74, 75
Dermoid cysts, branchial, xv, 183
— ovariotomy and, i, 41, 43
— sacrococcygeal, xv, 216
— scalp and, xv, 156
— umbilical, iii, 409
Desensitization, pollen fevers and, ix, 119
De Silvestri's typhoid urine color reaction, viii, 343
D'Espine's sign, bronchial gland tuberculosis and, xiv, 341
— elicitation of, bronchial gland tuberculosis and, ix, 208, 249
Desserts, caloric value of, x, 193
— diet of pregnancy and, i, 23
— normal child and, x, 124
Determinants, x, 21
Determination, development period of x, 75
Development, abnormal, dwarfism, xiii, 147
Development, abnormal, exogenous obesity, xiii, 137
— — fragilitas ossium, xiii, 164
— — infantilism, xiii, 145
— — Lorraine infantilism, xiii, 145
— — malnutrition, xiii, 139
— — microcephalus, xiii, 164
— — mongolism, xiii, 153
— — obesity, xiii, 137
— — osteomalacia and osteogenesis imperfecta, xiii, 164
— — osteopsathyrosis, xiii, 164
— — progeria, xiii, 162
— — true infantilism, xiii, 145
— anatomical, x, 51
— — bladder, x, 68
— — bones, x, 51
— — brain, x, 71
— — cerebellum, x, 72
— — extremities, x, 60
— — heart, x, 70
— — intestines, x, 66
— — kidneys, x, 67
— — liver, x, 67
— — lungs, x, 71
— — mammary glands, x, 68
— — muscles, x, 63
— — skull, x, 52
— — spine, x, 58
— — spleen, x, 67
— — stomach, x, 65
— — teeth, x, 56
— — thorax, x, 62
— — thymus, x, 69
— — thyroid, x, 69
— — uterus, x, 68
— — viscera, x, 65
— carbohydrate function in, x, 15
— charts for record of, iv, 193
— definition of, x, 51
— fat supplying energy for, x, 14
— first three years of, organs, tissue and traits during, x, 72
— four to six years of, organs, tissue and traits between, x, 74
— functional periods of, x, 72
— infant and child feeding and, xii, 7
— influence of food on, x, 1
— mental, malnutrition and, x, 107
— mineral salts and, x, 17
— normal child defined, x, 90

Development, overdevelopment and underdevelopment, x, 142
— physical, height and weight and, iv, 28
— — preventive pediatrics and, iv, 14
— precocious sexual, symptoms of, xiii, 99
— prematurity and increased rate of, xii, 100, 102
— proteins and tissue building in, x, 11, 13
— seven to ten years of, organs, tissue and traits between, x, 75
— sociological periods of, x, 50
— sunshine and, x, 25
— ten to sixteen years of, organs, tissue and traits between, x, 76
— underdevelopment and overdevelopment, x, 134
— vitamins and, x, 20
— water and, x, 19
Development record for preschool age, iv, 193, 194, 195, 196
Developmental bone diseases, achondroplasia, xv, 119
— cretinism or congenital myxedema, xv, 120
— dyschondroplasia, xv, 121
— multiple cartilaginous exostoses, xv, 121
— myositis ossificans traumatica, xv, 124
— osteitis fibrosa cystica, xv, 122
De Vigo, syphilis described by, xvii, 7
Dexterity, development period of, x, 75
Dextrimaltose, infant feeding and, i, 146
Dextrin-maltose, artificial feeding with, ii, 158
Dextrocardia, iii, 105
— anatomical considerations of, xviii, 136
— clinical aspects of, xviii, 146
— electrocardiographic determination of, xviii, 184
Dextrose, acute follicular tonsillitis and, ix, 55
— adenoidectomy and, ix, 73
— metabolism of, xiii, 13
Dextrose tolerance, alimentary, comparison of children and adults with regard to, xx, 159
Dextroversion, aortic, iii, 108
Dhobie itch, xvi, 194
Diabetes insipidus, diagnosis of, xiii, 86, 102
— heredity and, iv, 8
— pituitary involvement and, xiii, 85
— polyuria differentiated from, xix, 64
— symptoms of, xiii, 85
— treatment of, xiii, 86
Diabetes mellitus, acidosis in, xiii, 101
— adenoidectomy contraindicated in, ix, 74
— blood findings in, xiii, 101, 102
— coma in, xiii, 102
— differential diagnosis of, xiii, 103
— eczema and, xvi, 117
— hyperglycemia and, xiii, 14
— incidence of, xiii, 99
— insulin therapy in, xiii, 105
— ketosis-acidosis associated with, xiii, 29
— — treatment of, xiii, 30
— ketosis caused by, xx, 170
— metabolism in, xiii, 102
— prognosis of, xiii, 103
— renal, blood-sugar in, xx, 164
— respiratory quotient in, xiii, 101
— signs and symptoms of, xiii, 100
— treatment of, xiii, 103
— urine in, xiii, 101, 102
Diacetic acid, amount in blood, xx, 132
— carbohydrate deficiency and, x, 16
— Gerhardt's ferric chlorid reaction for, xx, 10
Diapedesis, original demonstration of, xi, 2
Diapers, ii, 129
— infant, care of, i, 172
Diaphragm, eventration of, xv, 253
— hernia of, clinical features of, xv, 248
— — physical signs of, xv, 251
— — treatment of, xv, 253
— — types of, xv, 247
— laryngeal, congenital, ix, 76
Diaphragmatic hernia, congenital, iii, 161

Diaphragmatic hernia, cyanosis and, ii, 205
Diaphysis, lesions, syphilitic infants and, i, 71, 78
Diarrhea, abuse of laxatives in, xii, 123
— acidosis and, x, 271; xiii, 26, 31
— acute inflammatory, course of lesions of, viii, 175
— — description of, viii, 173
— — diagnosis of, viii, 178
— — etiology of, viii, 173
— — lesions of, viii, 174
— — prognosis of, viii, 179
— — prophylaxis of, viii, 182
— — symptoms of, viii, 176
— — treatment of, viii, 180
— acute intestinal indigestion causing, viii, 166
— age incidence of, viii, 152
— boiling of milk preventing, iv, 52, 148
— breast feeding and, xii, 175
— Buhl's disease and, iii, 5
— classification of, viii, 153
— congenital syphilis and, iii, 59
— dehydration and, xiii, 41
— dyspepsia of artificially fed infants causing, viii, 161
— dyspepsia in breast-fed infants causing, viii, 158
— dyspepsia in premature infants causing, viii, 153
— etiology of, viii, 153
— fats causing, xii, 45
— feeding and, viii, 150
— general considerations of, iii, 175; viii, 149
— infant mortality and, iv, 111
— "infectious," cerebral palsies caused by, v, 142
— influenza in newborn and, iii, 29
— intestinal indigestion and, xii, 122
— irregular frequent feeding causing, xii, 90
— ketosis caused by, xx, 170
— mortality from, viii, 149
— newborn, initial, ii, 93
— — peculiarity of, ii, 172
— — unimportance of, ii, 7
— origin of, viii, 167
Diarrhea, paratyphoid fever in newborn and, iii, 30
— seasonal, xii, 124
— sepsis neonatorum causing, iii, 15
— starch indigestion causing, viii, 164
— tuberculous peritonitis and, viii, 281
— typhoid fever and, viii, 187
— Winckel's disease and, iii, 3
Diarrheal diseases of infants, milk infection and, xx, 122
Diastase, earliest digestive ferment, ii, 84
Diastasis, ventral hernia and, xv, 265
Diathermy, adenoids and, ix, 74
— lobar pneumonia and, ix, 167
Diathesis, tuberculous, xiv, 339
Diaz de Isla, evidence regarding syphilis recorded by, xvii, 5
Dibothriocephalus latus, morphology and identification of, xx, 82
Dichloramin-T, accessory nasal sinus disease and, ix, 36
Dick serum, scarlet fever and, xiv, 31
Dick test, scarlet fever and, iv, 136
Diet, alimentary anemia and, viii, 103
— average ratio of fat, protein and carbohydrates, iv, 40
— breakfast important, iv, 63
— candy and, iv, 63
— celiac disease and, viii, 215
— chronic constipation in childhood and, viii, 228, 230
— complemental feeding and, iv, 49
— cyclic vomiting and, viii, 137
— diabetes mellitus and, xiii, 104
— diffuse glomerulonephritis and, xix, 122
— energy quotient of, milk production and, xii, 160
— enuresis and, xix, 53
— esophageal stricture and, viii, 84
— gastric indigestion and, xii, 111
— gastro-intestinal infections and, iv, 147
— general remarks in relation to preventive pediatrics, iv, 63
— hypertrophic pyloric stenosis and, viii, 119, 121

Diet, infant feeding and preventive pediatrics, iv, 41
— ketosis-acidosis of anesthetization prevented by, xiii, 31
— ketosis caused by, xx, 170
— kidney stones and, xix, 182
— late infancy, iv, 55
— leukocytosis caused by, xx, 42
— mammary gland secretion and, ii, 141
— maternal, ii, 122
— — gestation and, iv, 16
— menus for two to six year period, iv, 59
— nephrosis and, xix, 93-100
— nursing mother's, xii, 181, 183
— obesity and, x, 153
— older child's, iv, 58
— orthostatic albuminuria and, xix, 62
— pellagra and, x, 262
— pregnancy, i, 21, 22-25, 164
— — breast milk and, i, 143
— — constipation and, i, 166
— — sepsis and, i, 98
— — toxemias and, i, 37
— preschool age, iv, 56
— preventive pediatrics and, iv, 39
— purine-free and high purine, composition of urine influenced by, xx, 23
— quantity of breast milk and, iv, 44
— respiratory diseases and, ix, 256
— rheumatic fever and, xviii, 55
— rheumatic infections and history of, xviii, 77
— rickets and, vii, 171
— school age, iv, 62
— subcutaneous fat controlled by, x, 33
— suggested day's list, x, 195
— supplemental feeding, iv, 50
— two to six year period, iv, 58
— typhoid delirium and, x, 213
— typhoid fever and, viii, 192, 193
— underfeeding and, iv, 45
— vomiting in infancy and, viii, 93
Diffuse glomerulonephritis, course of, xix, 114
— diagnosis of, xix, 118
— pathologic changes in, xix, 107
Diffuse glomerulonephritis, symptoms of, xix, 108
— treatment of, xix, 119
— uremia in, treatment of, xix, 124
Diffuse nephritis, chronic, chyluria in, xix, 67
Diffuse nephropathy, chronic, renal lesions in, xix, 125
— — vascular lesions in, xix, 127
Digestion, acidified milk aiding, xii, 21
— buffer action of acids and alkalies on, xii, 20
— calcium, x, 39
— carbohydrate, x, 33; xii, 46; xiii, 13
— chlorin, x, 41
— cost of, protein, xiii, 16
— — use of the term, xiii, 3
— disturbances of, rheumatic infections and, xviii, 82
— fat, x, 30; xii, 45; xiii, 16
— gastric, physiology of, viii, 89
— intestinal, viii, 141
— iron, x, 41
— magnesium, x, 40
— mineral salts, x, 38
— normal infant, charts showing progress in, xii, 3, 29, 59
— phosphorus, x, 41
— physiology of, xii, 54
— pregnancy and, i, 24
— protein, x, 36; xii, 50; xiii, 14, 16
— salts, xii, 53; xiii, 16
— sodium, x, 40
— starch, xii, 49
Digestive system, convulsions indicating supervision of, v, 137
— diseases of, abdominal examination in, viii, 267
— — abdominal tuberculosis, viii, 276
— — abscess of gums, viii, 13
— — accidental poisoning, viii, 310-315
— — actinomycosis of pharynx, viii, 40
— — acute catarrhal gastritis, viii, 104
— — acute dysentery, viii, 173
— — acute follicular tonsillitis, viii, 46
— — acute ileocolitis, viii, 173

Digestive system, diseases of, acute inflammatory diarrhea, viii, 173
—— acute intestinal indigestion, viii, 166
—— acute pharyngitis, viii, 39
—— acute tonsillitis, viii, 40
—— acute toxic gastritis, viii, 106
—— adenoid vegetations and, viii, 50
—— alimentary anemia in infancy, viii, 102
—— amebic dysentery, viii, 305
—— anal abnormalities and diseases, viii, 287
—— anal fissure, viii, 293
—— appendicitis, viii, 249
—— atony of stomach, viii, 94
—— biliary passage affections, viii, 328
—— cancrum oris, viii, 30
—— catarrhal stomatitis, viii, 22
—— celiac disease, viii, 206
—— chronic gastric indigestion, viii, 107
—— chronic intestinal indigestion, viii, 204
—— chronic ulcerative colitis, viii, 198
—— colic in infancy, viii, 98
—— congenital dilatation and hypertrophy of colon (Hirschsprung's disease), viii, 239
—— congenital microcolon, viii, 245
—— constipation, viii, 221, 226
—— cyclic vomiting, viii, 134
—— deficient appetite, viii, 219
—— dental hygiene and, viii, 69
—— diarrhea, viii, 149, 166, 173
—— dilatation of, viii, 108
—— disturbances in early infancy, viii, 100
—— drug dosage for children, viii, 342
—— dyspepsia of artificially fed infants, viii, 161
—— dyspepsia in breast-fed infants, viii, 158
—— dyspepsia in premature infants, viii, 153
—— epidemic parotitis, viii, 56
Digestive system, diseases of, esophageal affections, viii, 72, 74, 80
—— follicular stomatitis, viii, 24
—— food poisoning, viii, 315
—— foreign bodies in stomach, viii, 111
—— frenal ulcer, viii, 12
—— frozen milk and vomiting, viii, 95
—— gangrenous stomatitis, viii, 30
—— gastric hemorrhage, viii, 108
—— gastric insufficiency, viii, 94
—— gastro-enterospasm, viii, 126
—— geographic tongue, viii, 15
—— gingivitis, viii, 13
—— glossitis, viii, 16
—— hemorrhoids, viii, 293
—— herpes of lip, viii, 12
—— herpetic stomatitis, viii, 24
—— Hirschsprung's disease, viii, 239
—— hypertrophic pyloric stenosis, viii, 113
—— hypertrophy of gums, viii, 14
—— infantilism with fatty stools, viii, 206
—— intestinal obstruction and malformation, viii, 233
—— intestinal parasites, viii, 295, 299, 303
—— intestines and, viii, 139
—— intussusception, viii, 255
—— liver affections, viii, 324
—— maculofibrinous stomatitis, viii, 24
—— malformations and tumors of stomach, viii, 113
—— mechanical vomiting, viii, 92
—— Meckel's diverticulum and, viii, 245
—— mercurial stomatitis, viii, 36
—— Mikulicz's disease, viii, 55
—— necrosis of jaw, viii, 16
—— noma, viii, 30
—— non-epidemic parotitis, viii, 56
—— nursing and, viii, 97
—— pancreas affections, viii, 331
—— paratyphoid fever, viii, 195
—— peptic ulcer of duodenum, viii, 145
—— periostitis of gums, viii, 13
—— peritonitis, viii, 261, 276

Digestive system, diseases of, peritonsillar abscess, viii, 42
— — poisoning, viii, 310
— — proctitis, viii, 291
— — pylorospasm, viii, 126
— — quinsy, viii, 42
— — rectal abnormalities and diseases, viii, 287
— — rectal fissure, viii, 293
— — rectal polypus, viii, 294
— — retropharyngeal abscess, viii, 43
— — retropharyngeal lymphadenitis, viii, 43
— — Riga's disease of frenum, viii, 12
— — rôle of lymphoid disease in pharynx and fauces, viii, 48
— — rumination, viii, 130
— — salivary gland affections, viii, 52
— — salivary stones, viii, 58
— — sarcoma of jaw, viii, 17
— — scarlatinal tonsillitis, viii, 41
— — scurvy of gums, viii, 14
— — simple regurgitation, viii, 92
— — starch causing digestive injury, viii, 164
— — starvation fever in newborn, viii, 101
— — stomach disturbances, viii, 86, 104
— — stomatitis, viii, 19
— — sublingual inflammation, viii, 58
— — submaxillary inflammation, viii, 58
— — syphilis affecting salivary glands, viii, 59
— — syphilis of mouth, viii, 17
— — technical methods in pediatric practice, viii, 335
— — teeth and, viii, 60, 65
— — thrush, viii, 19
— — tongue-tie, viii, 2
— — tonsillar diphtheria, viii, 40
— — toxic vomiting, viii, 95
— — tumors and deformities of tongue, viii, 4
— — tumors of jaw, viii, 16
— — typhoid fever, viii, 184
— — ulcer of stomach, viii, 109
— — ulceration of hard palate, viii, 35
— — ulcerative stomatitis, viii, 26
Digestive system, diseases of, Vincent's angina, viii, 41
— — visceroptosis and, viii, 270
— — vomiting in infancy, viii, 92
— — vomiting of central origin, viii, 95
— — vomiting of intestinal influenza, viii, 95
— — worms, viii, 295, 299, 304, 309
— — x-ray diagnosis of, viii, 335
— newborn, anatomy of, iii, 124, 171
— — diseases of, iii, 188
— — injuries to, iii, 186
— — tumors of, iii, 193
Digitalis, acute decompensation during pregnancy treated with, i, 32
— bronchopneumonia and, ix, 136
— lobar pneumonia and, ix, 166
— sepsis neonatorum and, iii, 17
— stimulant use of, respiratory diseases and, ix, 265
Digitalization, indications for, heart-failure and, xviii, 219
Dilatation, cardiac, diagnosis of, xviii, 199
— cervix uteri, labor and, i, 89, 96
— — artificial, puerperal infections due to, i, 91
— — premature induction of, i, 109
— — rubber bags used in, i, 32
— colonic, congenital idiopathic, growth and prognosis of, xv, 2, 322
— — gastric, viii, 108
Dilution-concentration test, renal function and, xix, 40
Diminished breathing, ix, 92
Diphtheria, acute bronchitis and, ix, 101
— adenoids and, ix, 68
— bacteriology of, xiv, 158
— blood-count in, xi, 47
— bronchopneumonia following, ix, 122, 130
— "carriers" of, iv, 132; xiv, 182
— cerebral palsies caused by, v, 142
— character of cough of, ix, 99
— clinical course of, xiv, 162
— complications and sequelæ of, xiv, 165, 173

Diphtheria, convalescence of, xiv, 174
— definition of, xiv, 153
— diagnosis of, xiv, 167
— differential diagnosis of, xiv, 165
— etiology of, xiv, 154
— examination of throat cultures for, xx, 91
— heart complications in, xviii, 191
— history of, xiv, 153
— immunity and, xiv, 154, 178
— immunity transmission from mother to child, ii, 72
— intubation in, xiv, 172
— laryngeal, iii, 72; xiv, 163
— — foreign bodies in respiratory tract and, ix, 191
— — intubation in, xiv, 172
— leukocytosis in, xx, 43
— malignant, xiv, 164
— management of contacts, xiv, 181
— measles complicated by, xiv, 45
— milk as carrier of, xx, 122
— milk transmission of, xii, 13
— nasal, xiv, 163
— nephrosis and, xix, 78
— nervous sequelæ of, v, 80
— newborn "carriers" of, iii, 24
— — clinical characteristics of, iii, 24
— — prognosis of, iii, 25
— — virulence in newborn, iii, 25
— nursing of, xiv, 173
— palsies following, v, 80
— paralysis following, xiv, 166, 173
— pathology of, xiv, 160
— peripheral nerve injury and, vi, 251
— pharyngeal, xiv, 163
— prematurity caused by, ii, 163
— prevention of, iv, 132; xiv, 174
— prognosis of, xiv, 168
— Public Health regulations for, xiv, 185
— rheumatic infections and, xviii, 79
— scarlet fever differentiated from, xiv, 19
— Schick test in, principles of, iv, 133
— — technic of, xiv, 179
— — value of, xiv, 160
— skin, diagnosis of, xvi, 249
— — erythema scarlatiniforme and, xvi, 59
— — etiology of, xvi, 248
Diphtheria, skin, prognosis of, xvi, 249
— — symptoms of, xvi, 248
— — treatment of, xvi, 249
— symptoms of, xiv, 162
— tonsillar, viii, 40
— transmission of, xiv, 157
— treatment of, antitoxin, xiv, 170
— — general, xiv, 171
— — local, xiv, 171
— tuberculin test negatived by, ix, 231
— vaginal, xix, 229
Diphtheria antitoxin, administration of, xiv, 170
Diphtheritic laryngitis, ix, 80
Diphtheritic rhinitis, pathology of, ix, 16
— symptoms of, ix, 16
— treatment of, ix, 17
Diphtheritic sore-throat, acute follicular tonsillitis differentiated from, ix, 53
Diplococcus intracellularis meningitidis, cultural characteristics of, xx, 107
— groups of, xx, 108
Diploë, formation of, vii, 3
Discharge, bloody, prenatal care and, i, 46
Discrete variola, xiv, 91
Discs, optic, brain tumors affecting, v, 118
Disgust, preventive pediatrics and, iv, 70
Dislocations, ancient and recent, vi, 177
— birth, i, 127
— childhood and infancy, vii, 158, 159
— congenital, iii, 288
— epiphyseal, birth and, xv, 75
— hip-joint, congenital, vi, 288
— infancy and rarity of, xv, 67
— spontaneous of hip, vi, 224
— traumatic, iii, 292
Disobedience, preventive pediatrics and, iv, 77
Disseminated lupus, multiple, measles followed by, xvi, 226
District nurses, maternity protection and, i, 155, 156, 159
Diuresis, drugs for induction of, administration of, xix, 90, 121

Diuretin, hydrocephalus and, v, 116
Diurnal enuresis, xix, 51
Diverticulum, bladder, incidence of, xix, 203
— congenital intestinal, treatment of, xv, 280
— Meckel's, disturbances of, viii, 245
Dizziness, pregnancy and, i, 168
— toxemias and, i, 37
Dobell's solution, accessory nasal sinus disease and, ix, 36
— acute follicular tonsillitis and, ix, 56
— acute pharyngitis and, ix, 41
— acute rhinitis and, ix, 7
— antiseptic use of, respiratory diseases and, ix, 262
— atrophic rhinitis and, ix, 14
— hypertrophic rhinitis and, ix, 13
— septic sore-throat and, ix, 46
Dochez serum, scarlet fever and, xiv, 30
Dogs, diagnosis of rabies in, xiv, 327
— hydrophobia in, symptoms of, xv, 12
Donors, blood tranfusion, obstetrical services and, i, 104
Dosage, drug, formulæ for, viii, 342
Double mitral lesions, signs of, xviii, 118
Douches, abortion and, i, 48
— alcohol, puerperal infections contraindicating, i, 99
— gonorrhea and, i, 61
— lysol, premature cases and, i, 109
— pitcher, after labor, i, 95
— vaginal, delayed labor and, i, 96
Dover's powder, acute bronchitis and, ix, 105
— acute follicular tonsillitis and, ix, 56
— acute intestinal indigestion and, viii, 172
— bronchopneumonia and, ix, 135
— therapeutic use of, respiratory diseases and, ix, 264
Draft, the, breast feeding and, xii, 164
Drainage, intercostal, empyema and, xv, 232
— labor and, i, 97
Drainage, puerperal infections and, i, 98, 99
Dressings, sterile, puerperal infections and, i, 87
Dreuw's ointment, formula of, xvi, 349
Dried milk, composition of, xii, 32
— measurement of, xii, 33, 98
Dried milk preparations, infant feeding and, i, 146
Driving, pregnancy and, i, 24
Drooling, cerebral palsy causing, v, 149
Drop-foot, operation for, vi, 231
Drop-jaw, adenoids causing, ix, 70
Dropsy, pregnancy and, heart failure in, i, 30
Drug dosage, formulæ for, viii, 342
Drug eruptions, iii, 322
— German measles differentiated from, xiv, 66
— measles differentiated from, xiv, 49
— scarlet fever differentiated from, xiv, 19
Drugs, counterirritant use of, respiratory diseases and, ix, 258
— diuretic, administration of, xix, 121
— enuresis treated with, xix, 58
— nephrosis and, xix, 90
— therapeutic use of, respiratory diseases and, ix, 261
— treatment of heart-failure with, xviii, 218
Drüsenfieber, synonyms of, xiv, 314
Dry cupping, counterirritant use of, respiratory diseases and, ix, 258
Dry heat, counterirritant use of, respiratory diseases and, ix, 257
Dry pleurisy, ix, 192
Dry râles, significance of, ix, 97
Dryco, composition of, xii, 32
— measurement of, xii, 33, 98
— value as a substitute, xii, 28
Dublin treatment, convulsions at labor and, i, 39
— head indentations and, i, 113
DuBois' abscess, newborn, iii, 59, 96, 379
DuBois' linear formula, xiii, 11
Duchenne-Erb paralysis, iii, 226

Duchenne-Aran, progressive muscular atrophy of, vii, 251
Duchenne's paralysis, i, 123, 124
Ductless glands, newborn, iii, 371
Ductus Arantii, iii, 129
Ductus arteriosus, absence of, iii, 110
— obliteration of, causes of, ii, 53
— — prematurity and, ii, 166
— patent, prognosis of, iii, 116
Ductus Botalli, ii, 53
— absence of, iii, 110
— thrombosis in, iii, 118
Ductus venosus, anatomy of, iii, 129
Duke's disease, prevention undeveloped for, iv, 138
Duodenal contents, hydrogen-ion concentration of, xx, 91
Duodenal obstruction, malrotation causing, iii, 155
Duodenum, atresia of, iii, 135
— — hypertrophic pyloric stenosis differentiated from, viii, 120
— malformation of, viii, 236
— obstruction of, viii, 236
— — treatment of, xv, 277
— peptic ulcers of, viii, 145
— physiology of, viii, 140
Dura mater, v, 111
Dural hemorrhage, birth injuries and, i, 113
Dural septa, functions of, v, 23
— tears of, infant death and, i, 117
Dwarfism, achondroplasia (chondrodystrophia fœtalis), x, 137; xiii, 147
— etiology of, x, 135
— hypophyseal, xiii, 152
— infantilism and, xiii, 146
— Peltauf, xiii, 152
— primordial, xiii, 152
— recognized diseases associated with, xiii, 152
— renal, xx, 153
— signs of, x, 135
Dyes, dermatitis caused by, xvi, 42
Dynamic action, specific, xiii, 13
Dyostosis cleidocranialis, iii, 283
Dyschondroplasia, iii, 307
— characteristics of, vii, 29
— etiology of, vii, 27
— hereditary nature of, xv, 121
Dyschondroplasia, orthopedic considerations of, vi, 192
— treatment of, vii, 29
Dyscrasia, blood, vi, 125; xx, 51
— joints and, vi, 125
Dysentery, acute, bronchopneumonia secondary to, ix, 122
— — celiac disease differentiated from, viii, 214
— — course of lesions of, viii, 175
— — description of, viii, 173
— — diagnosis of, viii, 178
— — etiology of, viii, 173
— — lesions of, viii, 174
— — prognosis of, viii, 179
— — prophylaxis of, viii, 182
— — symptoms of, viii, 176
— — treatment of, viii, 180
— — typhoid fever differentiated from, viii, 192
— amebic, etiology of, viii, 305
— — lesions of, viii, 306
— — symptoms of, viii, 307
— — treatment of, viii, 308
— character of stools in, xx, 74
— newborn and, iii, 30
Dysidrosis, xvi, 93, 179
Dyskeratosis diffusa congenita, iii, 336
Dysmetria, v, 12
Dyspepsia, artificially fed infant, etiology of, viii, 161
— — physiological chemistry of, viii, 162
— — starch causing, viii, 164
— — symptoms of, viii, 162
— — treatment of, viii, 163
— breast-fed infant, diagnosis of, viii, 160
— — etiology of, viii, 158
— — prognosis of, viii, 161
— — symptoms of, viii, 159
— — treatment of, viii, 160
— premature infant, diarrhea caused by, viii, 153
— — treatment of, viii, 156
Dyspnea, aspiration of pleuritic effusion indicated by, ix, 198
— bronchopneumonia characterized by, ix, 128, 129, 131
— foreign bodies causing, ix, 188
— heart-failure and, xviii, 50

Dyspnea, rheumatic infections causing, xviii, 81
Dystocia, breast feeding affected by, ii, 150
— cysts and tumors causing, ovarian, i, 41
— operative delivery and, i, 19
Dystonia musculorum deformans, v, 71
— definition of, v, 1
Dystrophia adiposogenitalis, carbohydrate tolerance in, xiii, 85
— diagnosis of, xiii, 85
— infantilism and, xiii, 147
— symptoms of, xiii, 77
— treatment of, xiii, 85
— type of obesity in, xiii, 79
Dystrophy, facioscapulohumeral muscular (Landouzy and Déjerine type), vii, 255
— gait in, v, 12
— infant, hereditary syphilis and, i, 66
— muscular, vii, 253
— — clinical forms of, vi, 248
— — diagnosis of, vi, 249
— — etiology of, vi, 248
— — pathology of, vi, 248
— — prognosis of, vi, 249
— — progressive muscular atrophy differentiated from, vi, 247, 249
— — symptoms of, vi, 248
— — treatment of, vi, 249
— pseudohypertrophic, disability in, v, 63
— — Landouzy-Déjerine type of, v, 64
— — treatment, v, 65

Ear, birth injuries to, iii, 369
— cleansing of, ii, 126
— diseases of, iii, 368
— external, infections of, iii, 369
— hearing at birth, ii, 115
— infant, congenital syphilis affecting, i, 76
— infections of, malnutrition and, iv, 153
— malformations of, iii, 368
— meningitis from infection of, v, 85
Ear, middle, infections of, iii, 369
— tuberculosis of, xiv, 349
Earache, pollen fevers causing, ix, 118
Early congenital syphilis, pathology of, xvii, 21
Eating between meals, xii, 138
Eberth, typhoid fever and, xiv, 189
Ecchymotic rash, meningococcic meningitis causing, v, 89
Echinococcus cysts, xvi, 170
— lung and, ix, 186
Eclampsia, albuminuria and, ii, 108
— artificial feeding and, ii, 157
— nursing and, xii, 189
— pregnancy and, acidosis and, i, 130
— — Dublin treatment of, i, 39
— — maternal death-rate due to, i, 4
— — prenatal care in, i, 10, 39
— — puerperal sepsis following, i, 92
— — shock in, i, 130
— — toxemia of, i, 131
— — Stroganoff treatment of, i, 38
Eclamptic uremia, symptoms of, xix, 112
Ecthyma, diagnosis of, xvi, 210
— etiology of, xvi, 210
— impetigo contagiosa differentiated from, xvi, 207
— symptoms of, xvi, 210
— treatment of, xvi, 210
Ectodermal defect, major, iii, 317
Ectopia, abdominal, umbilical hernia and, iii, 156
Ectopia cordis, iii, 104
Ectopia testis, iii, 262
— etiological mechanism of, xix, 211
— incidence of, xix, 211
— treatment of, xix, 212
Ectopic pregnancies, ruptured, shock and, i, 133
Ectrodactylia, iii, 286
Ectromelia, iii, 283
Ectropion, pityriasis rubra pilaris and, xvi, 146
— uveal, iii, 356
— xeroderma pigmentosum and, xvi, 20
Eczema, iii, 327
— alopecia due to, xvi, 256
— asthma and, ix, 111
— childhood and, xvi, 115

Eczema, dermatitis herpetiformis differentiated from, xvi, 105
— diagnosis of, xvi, 117
— eczema seborrheicum differentiated from, xvi, 136
— erysipelas differentiated from, xvi, 215
— erythema multiforme differentiated from, xvi, 62
— etiology of, xvi, 115
— fat indigestion causing, xii, 78
— general considerations of, xvi, 108
— heredity and, iv, 11
— impetigo contagiosa differentiated from, xvi, 207
— infancy and, xvi, 113
— lichenification differentiated from, xvi, 141
— lupus erythematosus differentiated from, xvi, 242
— lupus vulgaris differentiated from, xvi, 228
— nail changes due to, xvi, 268
— papular urticaria differentiated from, xvi, 80
— pathology of, xvi, 117
— perléche differentiated from, xvi, 344
— poor nutrition causing, xii, 70
— prognosis of, xvi, 122
— prurigo differentiated from, xvi, 82
— scabies differentiated from, xvi, 166
— seborrheic, psoriasis differentiated from, xvi, 128
— — treatment of, xvi, 349
— symptoms of, xvi, 109
— treatment of, xvi, 118
— types of, xvi, 112
— vaccination and, xiv, 114
Eczema marginatum, xvi, 194
Eczema seborrheicum, diagnosis of, xvi, 136
— etiology of, xvi, 136
— pityriasis rosea differentiated from, xvi, 140
— prognosis of, xvi, 137
— symptoms of, xvi, 135
— treatment of, xvi, 137
Eczematous pores, xvi, 117
Edema, acute circumscribed, xvi, 76
Edema, acute foreign bodies in respiratory tract causing, ix, 191
— angioneurotic, diagnosis of, xvi, 77
— — etiology of, xvi, 77
— — hematuria and, xix, 69
— — pathology of, xvi, 77
— — prognosis of, xvi, 78
— — symptoms of, xvi, 77
— — synonyms of, xvi, 76
— — treatment of, xvi, 78
— brain injuries and, v, 25
— causes of, xix, 77
— concentration test for renal function in presence of, xix, 39
— diffuse glomerulonephritis and, xix, 108
— eclampsia and, i, 39
— heart-failure and, xviii, 49
— hereditary, of legs, xvi, 309
— laryngeal, iii, 72; ix, 83
— — mumps causing, xiv, 148
— lungs and, pregnancy and, i, 30, 32
— mechanism of production of, xix, 76
— nephrosis and, xix, 82, 84
— — treatment of, xix, 90
— newborn and, brain of, i, 137
— — epiphyseal junction of, i, 63, 72, 127
— — scalp of, i, 112
— — syphilitic and, liver tissues of, i, 74
— parenchymatous cardiac, syphilis causing, iii, 58
— peripheral nerve injury and, vi, 251
— pia-arachnoid, infantile paralysis causing, v, 103
— placenta and, syphilitic, i, 68
— prematurity and, ii, 166
— renal disease suggested by, xix, 75
— retinal, v, 18
— rheumatic carditis and, xviii, 89
— tapping and, xix, 93
— tonsillar, mumps causing, xiv, 148
— toxemias of pregnancy and, i, 37
— uvular, acute, ix, 48
Edema neonatorum, iii, 344
— etiology of, xvi, 307
— pathology of, xvi, 307
— scleroderma differentiated from, xvi, 305

Edema neonatorum, sclerema neonatorum differentiated from, xvi, 306
— symptoms of, xvi, 307
Edematous scleroderma, xvi, 302
Education, breast feeding, iv, 41
— cerebral palsy and, v, 152
— child hygiene and, iv, 172
— crippled children and, v, 210
— defective children and, v, 208
— delayed speech due to defective training, v, 195
— health, iv, 100
— health teaching in schools, iv, 175
— intermediate mental defects and, v, 209
— kindergartens and, iv, 92
— masturbation and, iv, 99
— menstruation and, iv, 98
— "nursery schools," iv, 92; v, 181
— parental, art of infant feeding and, xii, 144, 149
— pediatric practice and, v, 180
— physical disability and, v, 210
— prenatal care and, i, 12, 15, 149-175
— preschool age, iv, 92
— pubescent, iv, 91
— school hygiene and, iv, 180
— school life and, iv, 91
— sex, hygiene and, iv, 97
— speech defects and, v, 197
— venereal disease and, iv, 100
Effort syndrome, diagnosis of, xviii, 200
— rheumatic carditis and, xviii, 85
Effusion, pericardial, physical signs of, xviii, 125, 128
— — x-ray signs of, xviii, 160
— pleural, rheumatic fever complicated by, xviii, 128
— — treatment of, xviii, 222
— pleurisy with, diagnosis of, ix, 197
— — etiology of, ix, 195
— — lobar pneumonia differentiated from, ix, 155
— — pathology of, ix, 195
— — physical signs of, ix, 196
— — symptoms of, ix, 195
— — treatment of, ix, 198
Eggnog, whiskey, septic patients and, i, 98
Eggs, bottle feeding supplemented by, xii, 133
— diet of pregnancy and, i, 23, 165
— normal child and, x, 124
Eighth nerve, neurosyphilis involving, xvii, 197
Eiweissmilch, composition of, xii, 35
— infant feeding and, i, 145
Elastometer, Schade's, preëdema detected by, xix, 75
Elbow, acute infectious arthritis of, vi, 67
— acute traumatic arthritis of, vi, 122
— dislocations of, ancient and recent, vi, 178
— fixation of, vi, 44
— fracture of, vi, 156
— — peripheral nerve injury and, vi, 251
— malunited fractures of, vi, 171
— poliomyelitis and, vi, 225, 233
— postpartum fractures of, xv, 87
— — clinical features of, xv, 91
— — treatment of, xv, 92
— scar contractures of, vi, 209
— sprain of, vi, 122
— tennis, vii, 265
— — orthopedic management of, vi, 217
— tuberculosis of, management of, vi, 95; vii, 131
Electrical contractions, interpretation of, v, 134
Electrical hyperexcitability, tetany showing, v, 131
Electricity, cerebral palsies and, v, 146
— dermatitis caused by, xvi, 33
Electrocardiograms, normal adult, interpretation of, xviii, 166
— normal child, interpretation of, xviii, 168
Electrocardiography, ii, 59
— history of, xviii, 165
— methods of, xviii, 165
— value of, iii, 114; xviii, 165
Electrocauterization, pollen fevers and, ix, 120
Elephant's milk, chemical composition of, xii, 10
Elevation, scapular, congenital, iii, 383

Elimination, faulty, pregnancy and, i, 22
Elongated uvula, character of cough caused by, ix, 99
— treatment of, ix, 47
Emaciation, tuberculosis and, ix, 230
Embarrassment, development period of, x, 73
Embolic non-purulent glomerulonephritis, xix, 106
Embolism, cerebral and pulmonary, labor and, i, 11, 33
— pleurisy with effusion and, ix, 198
— pulmonary, heart disease and, xviii, 127
— rheumatic infections and, xviii, 83
Embryocardia, xviii, 192
Embryo development, abortions and, i, 45
— hereditary syphilis and, i, 66
Emetin, amebiosis and, ix, 186
Emotions, development period of, x, 73
— preventive pediatrics and, iv, 69
Emphysema, asthma causing, ix, 113
— bronchopneumonia and, ix, 126, 131
— etiology of, ix, 184
— newborn, iii, 90
— pathology of, ix, 184
— physical signs of, ix, 184
— subcutaneous, spontaneous, ix, 185
— — treatment of, xv, 220
— symptoms of, ix, 184
— treatment of, ix, 185
— whooping-cough complicated by, xiv, 124
Emphysematous breathing, ix, 94
Employment, prenatal care and, i, 156
Emptying time of newborn stomach, ii, 85
Empyema, age and seriousness of, xv, 3
— anemia caused by, xx, 50
— bacteriology of, xv, 228
— bilateral, management of, xv, 235
— blood-count in, xi, 70
— bronchopneumonia and, ix, 130
— character of cough of, ix, 100
— chronic, causes and treatment of, xv, 236
Empyema, complications of, ix, 204
— diagnosis of, ix, 200; xv, 230
— etiology of, ix, 199
— evidences of development of, ix, 159
— incidence of, xv, 225
— insufflation pneumonia causing, ix, 179
— lobar pneumonia differentiated from, ix, 156, 159, 200
— newborn, pathology of, iii, 95
— physical signs of, xv, 230
— prognosis of, ix, 204; xv, 230
— symptoms of, ix, 199; xv, 228
— treatment of, ix, 204; xv, 231
— tuberculous, treatment of, xv, 236
Encephalitis, cerebral palsies caused by vague form of, v, 142
— cerebral palsies due to, v, 147
— cerebrospinal cells in, v, 15
— congenital interstitial, iii, 245
— epidemic, alkalosis and, xx, 174
— — case history of chronic form of, v, 100
— — cerebrospinal fluid in, xx, 113
— — cerebrospinal meningitis differentiated from, xiv, 281
— — characteristic features of, v, 98
— — choked discs in, v, 99
— — chorea differentiated from, xviii, 61
— — choreiform movements in, xviii, 18
— — clinical course of, xiv, 257
— — definition of, xiv, 254
— — differential diagnosis of, xiv, 261
— — disorders of pons and, v, 217
— — etiology of, xiv, 255
— — history of, xiv, 254
— — infantile paralysis and, v, 98
— — influenza and, v, 97
— — laboratory findings in, xiv, 257
— — leukocyte counts in, xx, 44
— — lumbar puncture in, v, 99
— — pathology of, xiv, 256
— — prognosis of, xiv, 262
— — Public Health regulations for, xiv, 264
— — reflexes in, v, 101
— — sequelæ of, v, 99; xiv, 260

Encephalitis, epidemic, "sleeping sickness," v, 98
— — symptoms of, xiv, 257
— — synonyms of, xiv, 254
— — treatment of, xiv, 262
— — types of, xiv, 259
— — typhoid fever differentiated from, xiv, 201
— — vomiting and, viii, 95
— hemorrhagic, arsphenamin injections followed by, xvii, 272
— lead, cerebrospinal fluid in, xx, 115
— meningopolio-, v, 102
— paralysis of, hereditary syphilitic paralysis differentiated from, xvii, 249
— syphilitic, pathology of, xvii, 38
Encephalitis lethargica, newborn and, iii, 31
— synonyms of, xiv, 254
Encephalitis periaxialis, v, 219
Encephalocele, iii, 214; v, 50
— anatomy of, vii, 48
— definition of, xv, 152
Enchondromata, multiple, vi, 191
— — diagnosis of, vii, 28
— — etiology of, vii, 27
— — pathology of, vii, 28
— — treatment of, vii, 28
Encopresis, enuresis and, xix, 58
Encysted hydrocele, diagnosis of, xix, 213
Endemic multiple neuritis, x, 264
Endocarditis, accessory nasal sinus disease and, ix, 34
— acute, acute osteomyelitis differentiated from, vii, 70
— — acute rheumatic fever complicated by, vii, 94
— — blood-count in, xi, 47, 49
— adenoidectomy contraindicated in, ix, 74
— auricular, pathology of, xviii, 24
— bronchopneumonia secondary to, ix, 130
— chronic tonsilitis and, ix, 60
— erythema nodosum following, xvi, 64
— lobar pneumonia causing, ix, 159
— malignant, prognosis of, xviii, 186
— measles complicated by, xiv, 46
Endocarditis, metastatic abscesses from, iii, 118
— newborn, iii, 117
— pathology of, iii, 118
— pneumonia and, xviii, 191
— pregnancy and labor in, i, 29, 33, 34
— prevention of, iv, 126
— rheumatic, comparative incidence of valve injury in, xviii, 34
— — pathology of, xviii, 24
— scarlet fever complicated by, xiv, 21
— septic, typhoid fever differentiated from, xiv, 200
— subacute bacterial, diagnosis of, xviii, 190, 199
— — etiology of, xviii, 186
— — prognosis of, xviii, 186, 190
— — rheumatic carditis differentiated from, xviii, 186
— ulcerative, etiology of, xviii, 186
— valvular, pathology of, xviii, 27
— ventricular, pathology of, xviii, 24
— verrucous, pathology of, xviii, 186
Endocarditis lenta, xviii, 186
Endocrine changes, pregnancy and, i, 40
Endocrine disturbances, characteristics of, tabulation of, xiii, 108, 109
Endocrine glands, adrenal, xiii, 92
— bone disturbances and, vi, 192
— convulsions and disorders of, v, 138
— gonads, xiii, 95
— growth and, iv, 14
— interrelation of, xiii, 106
— mental disorders and, v, 171
— milk secretion inaugurated by, iv, 44
— pancreas, xiii, 99
— parathyroid, xiii, 71
— pineal, xiii, 74
— pituitary, xiii, 76
— pseudohypertrophic dystrophy and, v, 65
— thymus, xiii, 87
— thyroid, xiii, 44
— ultraviolet rays influencing, x, 26
Endocrine secretions, growth influenced by, xiii, 21
Endometritis, abruptio placentæ and, i, 52

Endometritis, bacteria causing, i, 88
— intercourse causing, i, 95
— puerperal infections causing, i, 89
— staphylococcus infections and, i, 104
— symptoms of, i, 93, 94
Endometrium, changes in, fetal death and, i, 48
Endothelial leukocytes, age and possible variation in number of, xi, 38
— formation and origin of, xi, 19
— morphology of, xi, 17
Endothelial myelomata, vii, 162
Endothelioma, Ewing's, vi, 199
Enemas, feeding by, nausea and, i, 26
— hygiene and, iv, 90
— method of therapeutic use of, respiratory diseases and, ix, 267
— soapsuds, i, 25, 169
— use of, ii, 137
Energy, carbohydrate as a source of, x, 15
— developmental peak of, x, 76
— fat as a source of, x, 14
— vitamins and, x, 21
Energy quotient, milk production and, xii, 160
Enlarged lymph-nodes, tonsillectomy and, ix, 60
Enlarged non-tuberculous bronchial glands, diagnosis of, ix, 209
— incidence of, ix, 206
— physical examination of, ix, 207
Enlargement of thymus, asthma caused by, xiii, 88
— diagnosis of, xiii, 89
— exophthalmic goiter and, xiii, 92
— prognosis of, xiii, 89
— signs and symptoms of, xiii, 88
— treatment of, xiii, 90
Enophthalmia, v, 27
Entamœba dysenteriæ, morphology and identification of, xx, 76
Entamœba histolytica, intestinal infestation with, viii, 305
— morphology and identification of, xx, 76
Enteric cysts, treatment of, xv, 339
Enteric fever, synonyms of, xiv, 188
Enteritis, acute, cerebrospinal meningitis differentiated from, xiv, 281
Enteritis, infant mortality and, iv, 111
— "initial diarrhea," iii, 192
— tuberculous, xiv, 352
Enterocolic intussusception, xv, 313
Enterokinase, ii, 89
— protein digestion and, x, 37
Enuresis, v, 199
— adenoids and, ix, 72
— age and, xix, 50
— diet in treatment of, xix, 53
— diurnal, xix, 51
— frequency of urination and, xix, 51
— general considerations of, xix, 47
— hereditary factors in, xix, 50
— miscellaneous causes of, xix, 50
— neuropathy of, xix, 48
— nocturnal, xix, 51
— onset of, xix, 51
— peripheral disturbances of bladder associated with, xix, 48
— psychic factors in, xix, 47
— recurrence of, xix, 52
— sex and, xix, 50
— sleep and, xix, 49
— symptoms of, subjective, xix, 53
— time and periods of, xix, 52
— treatment of, xix, 53
— urgency of urination and, xix, 51
— urinary changes in, xix, 50
Enuresis recidiva, incidence of, xix, 53
Environment, breast feeding and, i, 139
— cause of malnutrition during preschool age, iv, 160
— general considerations of, ii, 2
— heredity and, iv, 8, 12
— malnutrition and, iv, 162
— mental ability and, iv, 9
— mental status influenced by, v, 160, 167
— mortality rate and, iv, 12
— "nervousness" and, iv, 164
— psychology of infancy and, xii, 149
— rheumatic heart disease and, xviii, 12
— syphilis and, i, 77
Eosinophilia, asthma and, ix, 113
— dermatitis herpetiformis and, xvi, 104

Eosinophilia, diseases associated with, xi, 54
— newborn showing, xx, 35
Eosinophils, age and possible variation in number of, xi, 38
— functions of, xi, 6
— morphology of, xi, 16
Epidemic cephalalgia, synonyms of, xiv, 265
Epidemic cerebrospinal meningitis, synonyms of, xiv, 265
Epidemic encephalitis, alkalosis and, xx, 174
— case history of, v, 100
— cerebrospinal fluid in, xx, 113
— cerebrospinal meningitis differentiated from, xiv, 281
— characteristic features of, v, 98
— choked discs in, v, 99
— chorea differentiated from, xviii, 61
— choreiform movements in, xviii, 18
— clinical course of, xiv, 257
— definition of, xiv, 254
— differential diagnosis of, xiv, 261
— disorders of pons and, v, 217
— etiology of, xiv, 255
— history of, xiv, 254
— infantile paralysis and, v, 98
— influenza and, v, 97
— laboratory findings in, xiv, 257
— lenticular degeneration and, v, 72
— leukocyte counts in, xx, 44
— lumbar puncture in, v, 99
— pathology of, xiv, 256
— prognosis of, xiv, 262
— Public Health regulations for, xiv, 264
— reflexes in, v, 101
— sequelæ of, v, 99; xiv, 260
— "sleeping sickness," v, 98
— symptoms of, xiv, 257
— synonyms of, xiv, 254
— treatment of, xiv, 262
— types of, xiv, 259
— typhoid fever differentiated from, xiv, 201
— vomiting and, viii, 95
Epidemic grip, synonyms of, xiv, 379
Epidemic infantile paralysis, vii, 240
— synonyms of, xiv, 224
Epidemic infectious adenitis, acute, synonyms of, xiv, 314
Epidemic influenza, synonyms of, xiv, 379
Epidemic parotitis, iii, 198
— synonyms of, xiv, 141
Epidemic poliomyelitis, cerebrospinal cells in, v, 15
Epidemic salivary gland infection, viii, 56
Epidemic sore-throat, epidemiology of, ix, 44
— etiology of, ix, 45
— symptoms of, ix, 45
— synonyms of, xiv, 308
— treatment of, ix, 46
Epidemischer scarlatinosa, synonyms of, xiv, 320
Epidermolysis bullosa, iii, 332
— etiology of, xvi, 19
— nails affected by, xvi, 269
— pathology of, xvi, 19
— pemphigus neonatorum differentiated from, xvi, 213
— pemphigus vulgaris differentiated from, xvi, 101
— symptoms of, xvi, 18
— treatment of, xvi, 19
Epidermophyton, pompholyx and, xvi, 93
Epidermophyton inguinale, xvi, 194
Epididymis, tuberculosis of, xv, 371
Epididymitis, iii, 272
— acute, xv, 371
— symptoms of, xix, 219
Epigastric hernia, treatment of, xv, 266
Epignathia, iii, 131
Epilepsy, aura in, v, 138
— breast feeding prevented by, ii, 150
— drug treatment of, v, 139
— educational possibilities and, v, 211
— "essential," v, 128
— fever resulting in, v, 79
— grand mal, v, 138
— heredity and, v, 61, 139
— ketogenic diets in treatment of, xx, 171
— marriage and, v, 140
— neurosyphilis and, xvii, 197
— petit mal, v, 138

Epilepsy, prognosis in, v, 140
— pyknolepsy, v, 139
— treatment of, v, 139
— Wassermann reaction in, v, 82
Epinephrin, activities of, xiii, 92
— blood of newborn and, ii, 79
— stimulant use of, respiratory diseases and, ix, 266
Epiphyseal enlargement, rickets causing, vi, 182
Epiphyseal injuries, low-grade inflammations or trauma causing, vii, 73
Epiphyseal line conditions, newborn, i, 124, 127
— arm fractures and, i, 123
— edema at, simulating antenatal syphilis, i, 62, 72
— osteochrondritis at, syphilitic infants and, i, 70-73
— x-ray of, test for congenital syphilis and, i, 78
Epiphyseal separations, vi, 166
— birth and, xv, 75
— general considerations of, xv, 66
Epiphysitis, acute, diagnosis of, vii, 70
— — differential diagnosis of, vii, 149
— — hip-joint dislocation and, vii, 60
— — osteomyelitis and, vii, 69
— — osteomyelitis in infants and, xv, 137
— — symptoms of, vii, 69
— extra-articular, generalized, vi, 146
— — Köhler's disease and, vi, 145
— — os calcis and, vi, 144
— — Osgood-Schlatter's disease and, vi, 146
— — scaphoid and, vi, 145
— — tibial tubercle and, vi, 146
— inherited syphilis causing, xvii, 113
— scurvy differentiated from, x, 226
— syphilitic, incidence of, xvii, 131
— — treatment of pseudoparalysis following, xvii, 281
— tuberculosis of joints differentiated from, vi, 71
— tuberculosis of spine differentiated from, vi, 91
Epispadias, iii, 267; xv, 359
— embryology of, xix, 8
Epispadias, incidence of, xix, 214
Epistaxis, diagnosis of, ix, 19
— etiology of, ix, 18
— newborn, iii, 80
— pathology of, ix, 19
— predisposing factors, ix, 17
— prognosis of, ix, 19
— prophylaxis of, ix, 20
— renal, xix, 70
— scurvy causing, vii, 209
— symptoms of, ix, 19
— treatment of, ix, 20
— typhoid fever and, viii, 187
— whooping-cough causing, xiv, 124
Epithelial pearls, Bohn's, viii, 1
Epithelioma diagnosis of, xvi, 334
— etiology of, xvi, 334
— incidence of, xvi, 331
— multiple benign cystic, xvi, 27
— treatment of, xvi, 335
Eponychium, xvi, 266
Epsom salts, eclampsia and, i, 39
Epstein's pseudodiphtheria, iii, 188
Epulis, viii, 17
— origin of, xv, 181
Equinovarus, description of, vi, 280
— diagnosis of, vi, 281
— prognosis of, vi, 281
— treatment of, vi, 282, 286
Equivalent table, centimeters and inches, x, 290
Erb's muscular atrophy, vii, 256
Erb's paralysis, i, 123, 124; vii, 256
— Parrot's pseudoparalysis differentiated from, vii, 150
Erb's phenomenon, tetany and, xiii, 3
Erb's sign, details and significance of, vii, 194
— tetany or spasmophilia and, x, 251
Erb's spastic paraplegia, neurosyphilis and, xvii, 207
Erb's "upper arm" palsy, v, 26
Erepsin, ii, 89, 92
— protein digestion by, x, 37
Ergot, sapremia treated with, i, 93
Eructations, infant feeding and, i, 145
Eruptions, skin, drugs causing, iii, 322
— syphilitic, neonatal period and, i, 75
Erysipelas, acute osteomyelitis differentiated from, xv, 135
— blood-count in, xi, 47

Erysipelas, bronchopneumonia secondary to, ix, 122
— complications of, xiv, 401
— course of, xvi, 214
— definition of, xiv, 399
— diagnosis of, xiv, 401; xvi, 215
— eczema differentiated from, xvi, 118
— epistaxis and, ix, 18
— etiology of, xiv, 399; xvi, 215
— history of, xiv, 399
— infection in newborn, ii, 119
— leukocytosis in, xx, 43
— mortality from, ii, 4
— pathology of, xvi, 215
— prognosis of, iii, 19; xiv, 401; xvi, 215
— prophylaxis of, xiv, 401
— puerperal infections originating in, i, 86
— Ritter's disease differentiated from, xvi, 308
— scalp, xv, 155
— symptoms of, iii, 18; xiv, 400; xvi, 214
— synonyms of, xiv, 399
— transfusion in, iii, 17
— treatment of, iii, 20; xiv, 401; xvi, 215
— tuberculin test negatived by, ix, 231
— vulval, incidence of, xix, 229
— — treatment of, xix, 230
Erysipelas neonatorum, xiv, 400
Erysipèle, synonyms of, xiv, 399
Erysipeloid, etiology of, xvi, 216
— symptoms of, xvi, 216
— synonyms for, xvi, 215
— treatment of, xvi, 216
Erythema, eczema differentiated from, xvi, 117
— Jacquet's, iii, 319
— napkin, xvi, 35
— newborn, ii, 163
— toxic, xvi, 58
Erythema ab igne, xvi, 37
— passive hyperemia and, xvi, 57
Erythema elevatum diutinum, xvi, 240
Erythema gluteale, diagnosis of, xvi, 35
— etiology of, xvi, 35
— symptoms of, xvi, 35
— treatment of, xvi, 36
Erythema hyperæmicum, diagnosis of, xvi, 58
— symptoms of, xvi, 57
— treatment of, xvi, 58
Erythema induratum, diagnosis of, xvi, 236
— erythema nodosum differentiated from, xvi, 64
— etiology of, xvi, 236
— pathology of, xvi, 236
— symptoms of, xvi, 235
— treatment of, xvi, 236
Erythema infantum febrile, synonyms of, xiv, 320
Erythema infectiosum, definition of, xiv, 320
— diagnosis of, xiv, 323
— epidemiology of, xiv, 322
— etiology of, xiv, 322
— history of, xiv, 320
— symptoms of, xiv, 322
— synonyms of, xiv, 320
— treatment of, xiv, 323
Erythema intertrigo, iii, 320
— diagnosis of, xvi, 34
— symptoms of, xvi, 34
— treatment of, xvi, 34
Erythema iris, xvi, 60
Erythema multiforme, dermatitis herpetiformis differentiated from, xvi, 105
— diagnosis of, xvi, 62
— erythema nodosum and, xvi, 63
— etiology of, xvi, 62
—hydroa vacciniforme differentiated from, xvi, 97
— papular urticaria differentiated from, xvi, 80
— pathology of, xvi, 62
— pemphigus neonatorum differentiated from, xvi, 213
— pemphigus vulgaris differentiated from, xvi, 101
— prognosis of, xvi, 63
— symptoms of, xvi, 59
— treatment of, xvi, 63
— urticaria differentiated from, xvi, 75
Erythema nodosum, diagnosis of, xvi, 64
— erythema induratum differentiated from, xvi, 236

Erythema nodosum, etiology of, xvi, 64
— pathology of, xvi, 64
— prognosis of, xvi, 65
— rheumatic infection and, xviii, 73
— symptoms of, xvi, 63
— treatment of, xvi, 64
Erythema pernio, diagnosis of, xvi, 38
— etiology of, xvi, 37
— prognosis of, xvi, 38
— symptoms of, xvi, 37
— treatment of, xvi, 38
Erythema scarlatiniforme, diagnosis of, xvi, 59
— etiology of, xvi, 59
— scarlet fever differentiated from, xiv, 19
— symptoms of, xvi, 58
— treatment of, xvi, 59
Erythema serpens, xvi, 215
Erythema solare, xvi, 38
Erytheme induré des scrofuleux, xvi, 235
Erythredema, diagnosis of, x, 280; xiii, 135
— discovery of, xi, 5
— etiology of, x, 276, 278; xiii, 134
— pathology of, x, 278
— symptoms of, x, 277; xiii, 134
— treatment of, x, 281; xiii, 136
Erythredema polyneuritis, diagnosis of, xiii, 135
— etiology of, xiii, 134
— symptoms of, xiii, 134
— treatment of, xiii, 136
Erythroblastic anemia of childhood, blood changes in, xx, 59
Erythrocytes, abnormal forms of, xi, 15
— age and possible variation in number of, xi, 38
— average number of, xi, 39
— counting of, xi, 24
— destruction and formation of, xi, 14
— equilibrium between blood formation and destruction, xi, 13
— formation and destruction of, xi, 14
— formation from fetal life to childhood, xi, 12
— fragility of, determination of, xi, 29
— functions of, xi, 6
Erythrocytes, newborn characteristics of, ii, 67
— normal morphology and staining of, xi, 11
— number during adolescence, xi, 44
— number during childhood, xi, 43
— number during infancy, xi, 41
— original description of, xi, 1
— reproduction of, xi, 13
— variations in count of, ii, 67
Erythrocytosis, epistaxis and, ix, 18
Erythrodermia desquamativa, iii, 339
Erythrodermie congénitale ichthyosiforme, iii, 338; xvi, 17
Eskay's Food, xii, 43
Esophageal ulcers, hemorrhage from, iii, 183
Esophagus, abscess of, pleurisy caused by, ix, 193
— anatomy of, viii, 75
— congenital atresia of, iii, 135; viii, 72
— — treatment of, iii, 139
— congenital malformation of, viii, 72
— congenital narrowing of, viii, 74
— deformities of, iii, 135
— developmental errors of, xv, 272
— diseases of, viii, 74
— foreign bodies in, viii, 76; xv, 244
— hemorrhage from, iii, 183
— hypertrophy of musculature of, iii, 139
— membranous obstruction of, iii, 135, 137
— newborn, iii, 124
— normal development of, iii, 71
— physiology of, viii, 75
— safety pins in, viii, 76
— spasm of, viii, 80
— stricture of, course of, viii, 81
— — diagnosis of, viii, 83
— — pathology of, viii, 80
— — symptoms of, viii, 81
— — treatment of, viii, 83
— tracheal communication with, iii, 70
Essential epilepsy, v, 128
Essential hematuria, xix, 70
Essential hypertension, epistaxis and, ix, 18
Essential paralysis of children, vii, 240

Essential purpura, viii, 273
Essential thrombocytopenic purpura, surgical aspects of, xv, 51
Estivo-autumnal fever, etiology of, xiv, 210
— temperature charts of, xiv, 215, 216
Ether, administration of, xv, 30
— cardiac cases and, i, 33
— convulsions and, i, 38
— labor and, i, 169
— seminarcosis per rectum, labor of the tuberculous and, i, 29
— use during labor, ii, 123
Ether anesthesia, acute fasting with vomiting in, xiii, 25
Ethmoid sinus, examination of, ix, 24
Ethylene, anesthesia of the tuberculous at labor and, i, 29
— use during labor, ii, 123
Eugenics, heredity and, iv, 8, 9
Euglobulin, xx, 6
— colostrum and, ii, 90; xii, 160
— immune bodies carried by, ii, 73
Eunuchism, incidence of, xiii, 95
— manifestations of, xiii, 96
Evaporated milk, composition of, xii, 27
Eventration, iii, 161
— diaphragmatic, xv, 253
Ewing's endothelioma, vi, 199
Examination, abortion and, i, 46
— blood, laboratory, xvii, 43
— — routine procedures, xi, 23
— chest, ix, 87
— clinical, history in clinical cases, xv, 3
— — physical examination, xv, 4
— cystoscopic, preparation of patient for, xix, 44
— manual, elimination of, i, 96
— physical, surgery and, xv, 4
— postpartum, i, 160
— prenatal care and, i, 15, 16, 17
— spinal fluid, laboratory, xvii, 51
— — neurosyphilis and, xvii, 179
— vaginal, infections following, i, 87
Examination record, school age, iv, 197
Exanthem subitum, leukocyte count in, xx, 47
— prevention undeveloped for, iv, 138
Exanthem subitum, synonyms, xiv, 320
Exanthema variable, synonyms of, xiv, 320
Exanthemata, acute, blood-count in, xi, 47
Excitement, heart conditions during pregnancy and, i, 32
Excoratio umbilici, iii, 403
Excretion of acids, hydrogen-ion concentration of blood maintained by, xx, 168
Exercise, albuminuria caused by, xix, 60
— art of infant feeding and, xii, 146
— bronchopneumonia prophylaxis and, ix, 137
— chronic pneumonia and, ix, 170
— heart disease and, i, 32; xviii, 224
— heart murmurs affected by, xviii, 102
— hygiene and, iv, 85
— leukocytosis following, xx, 42
— obesity and, x, 154
— pregnancy and, i, 24, 168
— rheumatic infections and, xviii, 78
— subcutaneous fat controlled by, x, 33
Exercise and play during preschool age, iv, 85
Exercise and play during school age, iv, 85
Exertion, breast milk and, i, 144
Exfoliative dermatitis, arsphenamin injections causing, xvii, 274, 277
— nails affected in, xvi, 269
Exhaustion, heat, infancy and, viii, 102
— labor, breast feeding and, i, 141
— physical, prematurity caused by, ii, 162
Exhibits, Public Health, prenatal and infant care and, i, 157
Exogenous obesity, metabolism of, xiii, 137
— treatment of, xiii, 138
Exophthalmic goiter, prematurity caused by, ii, 163
— prognosis of, xiii, 49
— symptoms of, xiii, 47

Exophthalmic goiter, telangiectasia in, xvi, 295
— tests of thyroid function in, xiii, 48
— thymous in, xiii, 92
— treatment of, xiii, 49
Exostoses, multiple cartilaginous, xv, 121
— — clinical signs and symptoms of, vii, 21
— — complications of, vii, 26
— — diagnosis of, vii, 25
— — etiology of, vii, 20
— — localization of lesions of, vii, 22
— — microscopic anatomy of, vii, 24
— — pathology of, vii, 23
— — symptoms of, vii, 21
— — treatment of, vii, 26
— — x-ray appearance of, vii, 25
— osteomata and, xv, 125
Exotoxins, characteristics of, xiv, 3
Expectant mother, care of, ii, 121
Expectoration, tuberculosis and, ix, 229
Experimental hyperthyroidism, xiii, 71
Experimental nephritis, physiological findings from, xix, 24
Exploratory puncture, abscess of lung and, ix, 174
Expression of disease, peculiarities in, later infancy and childhood and, xii, 140
Exsanguination, delivery and, i, 91
— — blood transfusion in, i, 104
— — Credé expression causing, i, 97
— infant, i, 112
— placenta prævia and, i, 60
Exstrophy, bladder, iii, 266
— — clinical features of, xv, 357
— — embryology of, xix, 8
— — treatment of, xv, 358; xix, 198
External genitalia, embryology of, xix, 6
Extra-articular epiphysitis, orthopedic considerations of, vi, 144, 146
Extract, corpus, luteum, milk secretion and, ii, 142
— fetal, milk secretion and, ii, 142
— pituitary, milk secretion and, ii, 142
— placental, milk secretion and, ii, 142
Extrapyramidal cerebral palsy, v, 148, 151
Extrasystole, electrocardiographic determination of, xviii, 183
— respiratory, pregnancy and, i, 31
Extra-uterine asphyxia, ii, 201
— symptoms of, ii, 194
Extremities, comparison of adult and infant, vii, 9
— development of, x, 60, 76, 77
— fevers affecting length of, x, 211
— injury to, birth, i, 121
— lower, congenital malformations of, vii, 57
— malformations of, iii, 283
— proportions of, ii, 29
— upper, congenital malformations of, vii, 55
Exudate, examination of, xx, 92
— transudate differentiated from, ix, 197
Eyes, accommodation paralysis, v, 80
— appearance at birth, ii, 12
— birth injuries of, iii, 363
— care after birth, ii, 124
— congenital anomalies of, iii, 354
— diseases of, iii, 363
— early characteristics of, ii, 7
— ectoderm and mesoderm malformations, iii, 356
— embryology of, iii, 354
— enophthalmia, v, 27
— infant's, care of newborn, i, 62, 137, 169
— — congenital syphilis and, i, 76
— — gonococcal infection and, i, 62, 94
— — prenatal care and, i, 16
— intra-uterine inflammation and, iii, 360
— malnutrition and defective vision, iv, 156
— neurological examination of, v, 10, 17
— optic vesicle malformation causing anomalies of, iii, 355
— palpebral fissure narrowing, v, 9
— physiology at birth, ii, 114
— pollen fevers and, ix, 118
— pregnancy and, i, 168
— — toxemias of, i, 37
— pubescence showing increase in visual defects, iv, 121

Eyes, retinal examination in meningitis, v, 85
— retinal findings in encephalitis, v, 99
— small pupil signs, v, 27
— syphilis of, early manifestations of, xvii, 137
— — late manifestations of, xvii, 144
— — pathology of, xvii, 35
— syphilitic stigmata of, xvii, 225
— tuberculosis of, xiv, 349
Eye-grounds, brain tumors and, v, 118
— convulsions affecting, v, 137
— diffuse glomerulonephritis and, xix, 109, 110

Face, maldevelopments of, etiology of, vii, 54
— — nutritional care in, vii, 54
— surgery of, acute retropharyngeal abscess, xv, 178
— — cleft-palate, xv, 166
— — congenital cleft lip, xv, 166
— — congenital tongue-tie, xv, 174
— — cysts, xv, 173
— — harelip, xv, 166
— — macroglossia, xv, 175
— — macrostomia, xv, 173
— — ranula, xv, 176
— — ulcers of frenum, xv, 175
Face presentation, molding from, ii, 25
Facial paralysis, newborn, i, 125, 127
Facial puffiness, pregnancy and, i, 168
Facioscapulohumeral muscular dystrophy (Landouzy and Déjerine type), vii, 255
Factitious urticaria, xvi, 74
— urticaria pigmentosa and, xvi, 29
Factory legislation, prenatal care of pregnant mothers and, i, 24, 156
Faintness, abruptio placentæ and, i, 54
Fallen arch, supports for, vi, 259
Fallen viscera, orthopedic considerations of, vi, 272
Fallopian tubes, anomalies and malformations of, iii, 263
— embryology of, xix, 6
Falls, abortion and, i, 45
Falx cerebri, protection afforded by, v, 21
— tears of, birth, i, 112, 133
— — infant death caused by, i, 117
Familial conditions, nervous system and, v, 60
Familial effects of syphilis, incidence of infection, xvii, 100
— morbidity incidence, xvii, 109
— physical and mental stigmata, xvii, 106
— postnal mortality, xvii, 103
— responsibility for, xvii, 95
— social aspects, xvii, 110
— sterility and conception, xvii, 96
— stillbirths, xvii, 97
Familial hematuria, xix, 70
Familial hemolytic anemia of childhood, blood changes in, xx, 59
Familial hemolytic icterus, case history of, xi, 116
Familial icterus, iii, 200
Familial icterus gravis, ii, 214
Familial idiocy, amaurotic, general considerations of, iii, 255; v, 219
Familial jaundice, blood changes in, xx, 61
Familial lenticular degenerations, v, 61, 71
Family psychology, induction of labor and, i, 110
Farsightedness, prevalence of, iv, 156
Fascia, affections of, orthopedic, vi, 49
Fasting, acute, symptoms of, xiii, 24
— — treatment of, xiii, 24
— blood-sugar during, xiii, 14
— ketosis-acidosis associated with, xiii, 28
— pathological physiology of, xiii, 23
Fat, absorption of, x, 31; xii, 45
— amount in blood, xx, 132
— average dietary ratio of, iv, 40
— blood of newborn and, ii, 79
— breast milk and, ii, 146
— caloric value of, x, 15; xiii, 16
— — various foods and, x, 192, 193
— chemistry of fetal varieties of, ii, 47
— constipation and, xii, 84
— deposition of, x, 32

Fat, digestion of, x, 30; xii, 45
— elimination of, xii, 46
— excessive deposition of, criteria of, x, 147
— fat-soluble vitamin A from, x, 15
— foods containing, x, 28
— formula changes involving, normal infant and, xii, 88
— function of, x, 32
— human milk, xii, 162, 165
— indigestion due to, xii, 78, 82, 84, 86
— infant's requirements of, x, 15
— intestinal digestion of, viii, 141
— metabolism of, x, 30
— milk containing, x, 27
— needs in older children, x, 15
— newborn digestion of, ii, 89
— normal child and, x, 124
— percentages of various kinds of, ii, 47
— physiological action of, xii, 45
— principal functions of, x, 14, 15
— subcutaneous, normal child's, x, 109
— tolerance for, xii, 46, 84
— transportation of, x, 32
— vitamin content of, x, 284; xii, 85
— vomiting caused by excess of, xii, 115
Fat indigestion, character of stools in, xx, 72
— infant feeding and, i, 145
Fat-soluble vitamin A, source of, x, 22
— value of, x, 22
Father, education of, maternity protection and, i, 156
— health of, abortions and, i, 45
— — fetal death and, i, 48
— responsibility of, i, 3
— size of, fetal size and, i, 19
— syphilitic infection of fetus through, i, 64, 66, 81
Fatigue, abortion and, i, 44
— breast milk and, i, 141, 144
— hygiene and, iv, 85
— malnutrition and, iv, 163
— newborn muscle susceptible to, ii, 112
— posture and, iv, 35
Fatty acids, absorption of, x, 31
Fatty degeneration, acute, blood changes in, xx, 52
Fatty degeneration, liver and, viii, 330
Fatty stools, infantilism with, viii, 206
Fauces, lymphoid disease and, viii, 48
Faucial tonsils, acute follicular inflammation of, ix, 51
— anatomy of, ix, 49
— chronic inflammation of, ix, 57
— function of, ix, 50
Faulty nutrition, prematurity caused by, ii, 162
Faulty posture, vii, 269
— correction of, x, 196
Favus, iii, 349
— alopecia due to, xvi, 256
— diagnosis of, xvi, 192
— etiology of, xvi, 191
— pathology of, xvi, 192
— prognosis of, xvi, 194
— psoriasis differentiated from, xvi, 129
— symptoms of, xvi, 188
— treatment of, xvi, 193
Fear, development period of, x, 73
— malnutrition and, iv, 164
— pregnancy and labor and, i, 17, 40, 51, 169
— preventive pediatrics and, iv, 69
Febrile albuminuria, nephrosis and, xix, 78
Fecal impaction, intestinal obstruction caused by, viii, 239
Feces, bacteriology of, xx, 74
— blood in, conditions showing, xx, 74
— carbohydrate indigestion stools, character of, xx, 72
— chemistry of, xx, 75
— curds in, significance of, xx, 72
— fat indigestion stools, character of, xx, 72
— intestinal parasites in, xx, 76
— mucus in, significance of, xx, 72
— protein indigestion stools, character of, xx, 72
— starvation stools, character of, xx, 72
— stools in infancy, abnormal, xx, 72
— — acidity of, xx, 71
— — character of, xx, 71

Feces, stools in the newborn, character of, xx, 71
Feeblemindedness, Binet tests for, v, 156
— classification of, v, 185
— difficult labor and, i, 112
— Fernald's scale for, v, 158
— forceps delivery and, i, 111
— heredity and, iv, 9; v, 61
— lack of moral sense and, iv, 10
— mental tests for, v, 154
— Stanford tests for, v, 157
— Wassermann reaction in, v, 82
Feeding, additions to bottle feeding, xii, 129-135
— — beef juice, xii, 132
— — broths, xii, 132
— — cereals, xii, 131
— — eggs, xii, 133
— — fruit juices, xii, 131
— — meats, xii, 133
— — time to make, xii, 129
— — types of food, xii, 130
— — vegetables, xii, 134
— — water between meals, xii, 130
— alimentary hemorrhage and, iii, 186
— artificial, iv, 51
— — danger of, i, 157
— bottle, i, 140, 141, 145
— breast, i, 139-148, 173, 174
— — advantages of, ii, 139
— — anatomical factors in, iv, 46
— — complemental feeding, iv, 49
— — diarrhea prevented by, iv, 148
— — diet of mother and, xii, 159, 166, 181
— — duration of each, xii, 174
— — education of mothers in, iv, 41
— — intervals in, xii, 167
— — management of, xii, 170
— — mechanical factors in, iv, 46
— — mortality statistics showing value of, iv, 42
— — physiology of, xii, 155
— — preventive pediatrics and, iv, 41
— — schedule for beginning, xii, 180
— — standards for successful nursing, xii, 184
— — technic of, iv, 42
— — weaning and, xii, 179
Feeding, cod-liver oil in, i, 146
— colic and, iii, 178
— complementary, i, 145, 146; iv, 49
— — breast feeding and, xii, 176
— congenital syphilis and, iii, 57
— constipation and, iii, 179
— dentition and, xii, 136
— development period of voluntary act of, x, 73
— eating between meals, xii, 138
— formula, sepsis and, i, 98
— inadequate, results of, xii, 70
— infant caloric requirements, iv, 53
— — overfeeding, iv, 47
— — patented and proprietary foods and, iv, 51
— — preventive pediatrics and, iv, 41
— — quantity of food given, iv, 52
— — regularity of nursing, iv, 44
— — underfeeding analyzed, iv, 45
— infant and child, additions to bottle feeding, xii, 129
— — art of, xii, 143
— — breast feeding, xii, 155, 170
— — candy, xii, 139
— — convulsions and, xii, 141
— — definition of, xii, 4
— — eating between meals, xii, 138
— — essential points in, xii, 64
— — food changes in gastric indigestion, xii, 109
— — food changes in intestinal indigestion, xii, 118
— — food requirements in normal children, xii, 57
— — food requirements in premature infant, xii, 96, 102
— — formula changes in normal infant, xii, 76
— — formulas, xii, 69, 72
— — growth and development and, xii, 7
— — intervals in, xii, 65, 80, 103, 137, 167
— — introductory remarks, xii, 1
— — later infancy and childhood, xii, 136
— — milk—its source and preparation, xii, 9
— — peculiarities in expression of disease, xii, 140

Feeding, infant and child, physiological action of food constituents, xii, 44
— — physiology of digestion, xii, 54
— — preparations from milk, xii, 23
— — psychology of infancy and, xii, 149, 151
— — reflexes and, xii, 140
— — regularity in, xii, 137
— — schedules for, xii, 137
— — selective eaters, xii, 139
— — standards for successful nursing, xii, 184
— — substitutes for milk, xii, 34
— — tolerance, xii, 7
— intervals in, xii, 65, 80, 103, 137, 167
— later infancy and childhood, dentition and, xii, 136
— — later changes in milk, xii, 136
— prematurity and, ii, 180
— regularity in, xii, 137
— schedules for, xii, 137
— selective eaters, xii, 139
— sour milk, viii, 338
— stomach-tube, xii, 104, 165, 190
— supplemental, iv, 50; xii, 174, 176
— thick, viii, 337
— tube, viii, 338
— types of infants and, xii, 5
Feet, hygiene and deformities of, iv, 88
— ringworm of, xvi, 178
— swelling of, pregnancy and, i, 162, 168
Feigned skin eruptions, xvi, 54
Female genital organs, anatomy of, xix, 19
— anomalies and malformations of, iii, 263
— diseases of, diphtheria of vagina, xix, 229
— — erysipelas of vulva, xix, 229
— — gonococcal infection, xix, 225
— — precocious puberty, xix, 223
— — simple vaginitis, xix, 228
— — tumors of ovary, xix, 223
— — tumors of vagina, xix, 224
— malformations of hermaphroditism, xix, 223
— — miscellaneous, xix, 222
Female gonads, underfunction of, xiii, 97
Femoral hernia, diagnosis and treatment of, xv, 265
Femur, birth fractures of, vi, 150; xv, 74
— congenital anomalies of, vi, 278
— fracture of, iii, 299
— — malunited, vi, 170
— — postpartum, xv, 103, 106, 109
— — shaft of, vi, 149
— syphilis at, illus., i, 73, 74
Fermentation, carbohydrate, xii, 48
Ferments, milk and, xii, 17, 37
— pancreatic, ii, 89
Fernel, description of syphilis by, xvii, 6
Ferric chlorid, gonorrheal condylomata treated with, i, 61
Fetal abnormalities, i, 48, 49
— prenatal care and, i, 8
Fetal age, estimation of, ii, 160
— length and weight and, ii, 161
Fetal ascites, umbilical hernia caused by, iii, 158
Fetal ash, amount of, ii, 46
— composition at various ages, ii, 47
Fetal bronchiectasis, iii, 92
— cyanosis caused by, ii, 205
Fetal chrondrodystrophy, bodily changes in, vii, 19
— body growth and, vii, 14
— etiology of, vii, 14
— pathology of, vii, 14
— prematurity and, vii, 11
— stillbirth and, vii, 11
— treatment of, vii, 19
— x-ray studies of, vii, 18
Fetal circulation, factors contributing to obstruction of, ii, 192
Fetal death, drugs during labor and, ii, 123
— syphilis and, xvii, 98
— syphilis causing, iv, 145
Fetal extracts, milk secretion and, ii, 142
Fetal heart, determination of quality of, ii, 123
Fetal heartbeat, mongolism and, xiii, 158

Fetal maldevelopment, placental infarcts causing, v, 141
— x-ray and, v, 141
Fetal metabolism, essence of, x, 49
Fetal movements, cessation of, pregnancy and, i, 50, 169
— abruptio placentæ and, i, 55
— death in utero and, i, 108
Fetal nutrition, prenatal growth and, x, 46
Fetal peritonitis, iii, 206; viii, 261
— intestinal atresia following, iii, 146, 148
Fetal rickets, iii, 306; vi, 192; vii, 11, 174
— bodily changes in, vii, 19
— body growth and, vii, 14
— etiology of, vii, 14
— pathology of, vii, 14
— treatment of, vii, 19
— x-ray studies of, vii, 18
Fetal skull, resistance to forces of labor, v, 22
Fetal smallpox, xiv, 92
Fetal syphilis, i, 49; xvii, 2
Fetal weight, diet of mother and, ii, 122
Fetus, growth from conception to birth, x, 43
— infection of, iii, 10
— length of, age estimated by, ii, 161
— macerated, i, 48, 49
— — syphilitic lesions at epiphyseal junction in, i, 72
— oversize of, i, 19
— — premature labor and, i, 107, 108
— syphilitic infection of, time of, xvii, 72
Fever, acute catarrhal, ix, 1
— acute rheumatic, xiv, 388
— — blood-count in, xi, 47, 49
— — complications of, vii, 95
— — diagnosis of, vii, 95
— — etiology of, vii, 90
— — leukocyte counts in, xx, 44
— — pathology of, vii, 92
— — prognosis of, vii, 98
— — scurvy differentiated from, vii, 211
— — Still's disease differentiated from, vii, 104
Fever, acute rheumatic, symptoms of, vii, 92
— — treatment of, vii, 97
— autumn, ix, 117
— black, xiv, 265
— black water, hemoglobinuria in, xix, 68
— brain, xiv, 265
— cerebrospinal, xiv, 265
— dehydration, ii, 208; x, 215; xiii, 40
— — diagnosis of, ii, 211
— estivo-autumnal, xiv, 210
— factors producing, xiii, 38
— glandular, ix, 44; xiv (308), 314
— — blood changes in, xx, 55
— hay, ix, 117
— inanition, complemental feeding and, ii, 156
— — congenital esophageal atresia causing, iii, 137
— — early appearance of, ii, 7
— — water content of blood and, ii, 76
— — water deprivation and, x, 215
— length of extremities and, x, 211
— lung, ix, 137
— malarial, xiv, 209
— metabolism and, xiii, 5
— paratyphoid, bacteriology of, viii, 195
— — complications of, viii, 197
— — diagnosis of, viii, 198
— — etiology of, viii, 195
— — general considerations of, viii, 195
— — lesions of, viii, 196
— — prognosis of, viii, 198
— — symptoms of, viii, 196
— — treatment of, viii, 198
— pathological physiology of, xiii, 38
— pollen, classification of, ix, 117
— — complications of, ix, 118
— — diagnosis of, ix, 118
— — etiology of, ix, 117
— — prophylaxis of, ix, 120
— — susceptibility and, viii, 317
— — symptoms of, ix, 118
— — treatment of, ix, 119
— remittent, xiv, 209
— rheumatic, blood changes in, xviii, 54

Fever, rheumatic, blood-vessel pathology of, xviii, 37
— — brain pathology and, xviii, 18
— — chorea and, xviii, 18
— — communicability of, xviii, 75
— — convalescent care of, xviii, 58, 217
— — heart pathology of, xviii, 21
— — joint pathology and, xviii, 18
— — kidney pathology in, xviii, 40
— — lung pathology of, xviii, 39
— — pathogenesis of, xviii, 16
— — pathology of, xviii, 18
— — pericarditis and, xviii, 124
— — pleural effusion and, xviii, 128
— — pleural involvement in, xviii, 39
— — pleurisy following, ix, 193
— — salicylates in treatment of, xviii, 216
— — scarlet fever and, xviii, 192
— — scope of the term, xviii, 51
— — subcutaneous nodules and pathology of, xviii, 19
— — summary of pathology of, xviii, 40
— — tendency to recurrence of, xviii, 211
— — treatment of, xviii, 55, 216
— salt, xiii, 40
— scarlet, xiv, 10
— — growth affected by, xiii, 22
— — heart complications in, xviii, 192
— — leukocytosis in, xx, 45
— — milk as carrier of, xx, 122
— — milk transmission of, xii, 14
— — rheumatic infections and, xviii, 78
— — vaginitis associated with, xix, 229
— spotted, xiv, 265
— starvation, newborn and, viii, 101
— swamp, xiv, 209
— thermic, infancy and, viii, 102
— transitory, dehydration causing, ii, 208
— — diagnosis of, ii, 211
— — symptoms of, ii, 209
— — temperature in, ii, 210
— tuberculosis and, ix, 229
— typhoid, xiv, 188, 194
Fever, typhoid, acute osteomyelitis differentiated from, vii, 70
— — age incidence of, viii, 184
— — anemia secondary to, xi, 69
— — blood-count in, xi, 47, 51
— — bronchopneumonia following, ix, 130
— — complications of, viii, 190
— — course of, viii, 190
— — descriptive summary of, viii, 184
— — De Silvestri's color reaction in urine in, viii, 343
— — diagnosis of, viii, 191
— — diet and delirium in, x, 213
— — empyema and, ix, 201
— — epistaxis in, ix, 18
— — etiology of, viii, 185
— — heart complications in, xviii, 192
— — icterus index in, xx, 40
— — incidence of, viii, 184
— — incubation period of, viii, 187
— — leukopenia in, xx, 46
— — miliary tuberculosis and, viii, 191
— — milk as carrier of, xx, 122
— — milk transmission of, xii, 13
— — pathological physiology of fever in, xiii, 39
— — pathology of, viii, 185
— — plateau and stepladder types of temperature in, viii, 187
— — pneumonia and, viii, 191
— — prognosis of, viii, 194
— — prophylaxis of, viii, 194
— — relapse in, viii, 190
— — rheumatic infections and, xviii, 79
— — symptoms of, viii, 186
— — treatment of, viii, 192
— — tuberculin test negatived by, ix, 231
— — vaccine therapy of, viii, 193
— — Widal reaction in, viii, 342
— typhus, blood-count in, xi, 47
— — leukocyte count in, xx, 45
Fever and ague, synonyms of, xiv, 209
Fever blister, xvi, 84
Fibrillation, auricular, death from, labor and, i, 33

Fibrillation, auricular, electrocardiographic determination of, xviii, 180
— ventricular, electrocardiographic determination of, xviii, 180
Fibrinogen, clotting and, ii, 232
— plasma, significance of, xx, 130
Fibrinous bronchitis, character of cough of, ix, 100
— etiology of, ix, 106
— symptoms of, ix, 106
— treatment of, ix, 107
Fibrinous pericarditis, pathology of, xviii, 35
Fibrinous pleurisy, ix, 192
— rheumatic infection complicated by, xviii, 39
Fibrinous pneumonia, ix, 137
Fibrocystic osteitis, vii, 80
Fibroma, joints and, vi, 126
— recurrent bone, vi, 196
— umbilical, iii, 409
Fibromyomata, abruptio placentæ and, i, 52
— prenatal care and, i, 42
— removal of, i, 43
Fibrosis syphilitic infants and, liver of, i, 74, 75
— syphilitic osteochrondritis and, i, 72
— syphilitic placenta and, i, 68
Fibrous osteitis cystica, vi, 142
Fibrous osteomyelitis, chronic, vii, 80
Fibula, congenital anomalies of, vi, 278
— fracture of, peripheral nerve injury and, vi, 252
— postpartum fracture of, xv, 112
Fièvre ganglionnaire, synonyms of, xiv, 314
Fièvre paludéene, synonyms of, xiv, 209
Fièvre pernicieuse, synonyms of, xiv, 209
Figs, constipation during pregnancy and, i, 166
Filariasis, anemia secondary to, xi, 77
Fingers, abnormalities of, vii, 56
— clubbing of, xviii, 188, 199
— postpartum fractures of, xv, 103
— scar contractures of, vi, 207
— tuberculosis of, vii, 132
First molar, syphilitic hypoplasia of, xvii, 222
Fish, caloric value of, x, 192
— diet of pregnancy and, i, 23
— normal child and, x, 124
— vitamin content of, x, 285
Fissura abdominalis, iii, 157
Fissure, anal, viii, 293
— — clinical features of, xv, 345
— — newborn, iii, 196
— rectal, viii, 293
Fistula, anal, surgery of, xv, 348
— branchial, iii, 96
— — surgery of, xv, 184
— coccygeal, iii, 309
— congenital sacrococcygeal, surgery of, xv, 217
— laryngeal, ix, 76
— median (thyroglossal), xv, 186
— rectovaginal, iii, 167
— rectovesical, embryology of, xix, 8
— tracheo-esophageal, iii, 135
— umbilical, iii, 400
— — treatment of, xv, 282
— urachal, Meckel's diverticulum and, iii, 165
— — treatment of, xv, 282
Flaccid paralysis, v, 212; vii, 240
— whole arm type, v, 27
Flail-foot, vi, 223
Flannels, baby, care of, i, 172
Flatfoot, congenital, treatment of, vi, 286
— deformity in, vi, 257
— diagnosis of, vi, 258
— examination of, vi, 257
— symptoms of, vi, 257
— spina bifida occulta and, v, 52
— treatment of, vi, 258; vii, 275
— varieties of, vii, 274
Flat nipple, massage for, ii, 152
Fleas, iii, 348; xvi, 157
Flecken, synonyms of, xiv, 34
Flexner, serum for cerebrospinal meningitis produced by, xiv, 266
Flint murmer, xviii, 195
Flora, bacterial at birth, ii, 117
— intestinal, relation to transitory fever, ii, 208
— vulvar, ii, 119

Florid rickets, vii, 176, 186
Florid scurvy, pathology of, x, 224
Flour-butter mixtures, preparation of, xii, 39
Flugge contamination, tuberculosis and, xiv, 335
Fluids, administration of, ii, 133
Flutter, auricular, electrocardiographic determination of, xviii, 180
Focal glomerulonephritis, acute, hematuria caused by, xix, 69
— course of, xix, 103
— symptoms of, xix, 102
— treatment of, xix, 103, 106
Follicular impetigo, etiology of, xvi, 216
— pathology of, xvi, 216
— symptoms of, xvi, 216
— treatment of, xvi, 217
Follicular stomatitis, viii, 24
Follicular tonsillitis, acute, complications of, ix, 54
— — diagnosis of, viii, 47; ix, 53
— — diphtheria differentiated from, xiv, 168
— — etiology of, ix, 51
— — pathology of, ix, 51
— — prophylaxis of, ix, 54
— — scarlet fever differentiated from, xiv, 19
— — symptoms of, viii, 46; ix, 52
— — treatment of, viii, 47; ix, 54
Fontanel, hydrocephalus causing bulging of, v, 43
— intracranial pressure and bulging of, v, 10
— premature peculiarities of, ii, 164
— puncture of lateral ventricle through, v, 87
— size at birth, ii, 23
— special considerations of, vii, 7
Food, absorption of, intestinal, ii, 89
— administration of, ii, 133
— — premature infants and, ii, 180
— advance in knowledge of, x, 8
— alkali-producing, xix, 64
— amount required in prematurity, ii, 183
— animal, chemical composition of, x, 286
Food, antiscorbutic value of, table of, xiii, 127
— asthma and, ix, 110, 116
— body utilization of, xii, 57, 60
— bolting of, xii, 139, 154
— carbohydrate, x, 28
— chemical composition of, x, 286-289
— concentrated, cereal milk and, xii, 38
— dehydration fever and, ii, 212
— elements of, x, 10
— — caloric value of, x, 17
— — carbohydrate, x, 15
— — fat, x, 14
— — importance of proper proportion of, x, 11
— — mineral salts, x, 17
— — protein, x, 11
— — sources of, x, 26
— — sunshine, x, 25
— — vitamins, x, 20
— — water, x, 19
— fat, x, 28
— forms and sources of, x, 10
— gobbling of, xii, 139, 154
— growth and, ii, 39
— growth and quantity and quality of, xiii, 20
— growth influenced by, x, 87
— human development influenced by, x, 1
— indigestion and changes in, gastric, xii, 109
— — intestinal, xii, 118
— infant and child's, art of administering, xii, 143
— — breast feeding, xii, 155, 170
— — formulas for, xii, 69, 72, 76
— — growth and development and, xii, 7
— — introduction to, xii, 1
— — normal requirements in, xii, 57
— — physiological action of constituents of, xii, 44
— — physiology of digestion of, xii, 54
— — preparations from milk, xii, 23
— — source and preparation of milk, xii, 9
— — substitutes for milk, xii, 34

Food, infants and illness and use of, x, 194
— lactating animal's, chemical composition of milk and, xii, 10
— metabolism and type of, xiii, 12
— miscellaneous, chemical composition of, x, 286
— — chemical content of, x, 289
— — vitamin content of, x, 285
— normal child's, x, 117
— — bread, x, 124
— — cereals, x, 123
— — desserts, x, 124
— — eggs, fish, meat, x, 124
— — fats, x, 124
— — fruits, x, 123
— — milk, x, 123
— — soups, x, 124
— — vegetables, x, 123
— normal requirements of, xii, 57
— nursing mother's, xii, 181, 183
— obesity and, x, 153
— physiological action of constituents of, carbohydrates, xii, 46
— — fats, xii, 45
— — introduction, xii, 44
— — protein, xii, 49
— — salts, xii, 53
— — starches, xii, 49
— premature infant's requirements of, xii, 96
— — overweight and underweight, xii, 102
— proprietary, malnutrition and, iv, 152
— protein, x, 27
— quantity and quality affecting weight, ii, 43
— refinement affecting value of, x, 6
— regurgitation of, viii, 130
— rickets and, vii, 171
— salts in, x, 28
— scurvy and, vii, 205
— significance of the term, x, 10
— sources of elements of, x, 26
— — bulk, x, 28
— — fat, x, 28
— — milk, x, 27
— — protein foods, x, 27
— — salts, x, 28
— — vitamins, x, 28
Food, sources of elements of, water, x, 28
— transitory fever and, ii, 212
— uses of, pregnancy and, i, 165
— variety important, iv, 74
— vitamin A in, x, 28
— vitamin B in, x, 29
— vitamin C in, x, 29
— vitamin D in, x, 29
— vitamin content of, x, 23, 283-285
— vomiting in infancy and, viii, 93
— wolfing of, xii, 139, 154
Food factors, x, 21
Food habits, iv, 74
— preschool age, iv, 75
Food hormones, x, 21
Food idiosyncrasies, heredity and, xii, 95, 96
— indigestion and, xii, 6
Food poisoning, alimentary allergy, viii, 316
— botulism, viii, 315
— milk-sickness, viii, 320
Foot, acute infectious arthritis of, vi, 58
— congenital anomalies of, vi, 278
— deformities of, vi, 280; vii, 274
— — orthopedic management of, vi, 256
— — talipes, vi, 280
— flat, deformity in, vi, 257
— — diagnosis of, vi, 258
— — examination of, vi, 257
— — symptoms of, vi, 257
— — treatment of, vi, 258
— inspection of, vi, 12
— normal, structure and function of, vi, 256
— — x-ray of, vi, 2
— orthopedic examination of, vi, 12
— poliomyelitis and, vi, 220, 230
— scar contractures of, vi, 209
— tuberculosis of, diagnosis of, vi, 76; vii, 130, 132
— — symptoms of, vii, 130, 132
— — treatment of, vi, 78; vii, 131, 133
— weak, deformity in, vi, 257
— — diagnosis of, vi, 258
— — examination of, vi, 257
— — symptoms of, vi, 257
— — treatment of, vi, 258

Foot-and-mouth disease, milk as carrier of, xx, 122
Footprints, identification by, ii, 126
Foramen orale, closure of, ii, 53, 55, 130
— patency causing few deaths before 14th day, ii, 5
— patent, iii, 106
— — mongolism and, xiii, 157
— — prognosis of, iii, 116
— posture favoring closure of, ii, 130
— premature closure of, iii, 107
— prematurity and, ii, 166
Forceps delivery, birth palsy in, i, 125
— cardiac cases and, i, 32, 33
— clavicular fracture in, i, 121
— conservatism in, i, 19
— convulsions after, i, 116
— falx and tentorium ruptured in, i, 117
— feeble-mindedness and, i, 111, 112
— hematoma and, i, 125
— hemorrhages in, bulbar and medullary, i, 120
— lacerations and, i, 89
— placenta prævia and, i, 60
— skull injuries in, i, 116
Fordyce's disease, etiology of, xvi, 340
— symptoms of, xvi, 340
— treatment of, xvi, 340
Forearm, fracture of, vi, 151
— postpartum fracture of both bones of, xv, 95
Foreign bodies, air and food passages, xv, 240
— gastro-intestinal tract, xv, 244
— respiratory tract and, ix, 187
Foreign protein, serum disease from, xiv, 292
— treatment of heart disease by injections of, xviii, 216
Foreign protein sensitization, asthma and, ix, 110, 113
— pollen fevers and, ix, 117
Formaldehyd, accidental poisoning with, viii, 313
Formalin, acute infectious arthritis and, vi, 55
— tuberculous abscess and, vi, 76
Formalin, urine analysis and, i, 22
Formula, basic truths underlying, xii, 69, 72, 75
— complementary and supplementary feeding, xii, 177
— normal infant and changes in, xii, 76, 89
— — constituent changes, xii, 81, 89
— — interval changes, xii, 80
Formula feeding, i, 140
Formulary of preparations for treatment of skin diseases, xvi, 346
Fournier, parasyphilitic diseases of, xvii, 13
— researches on syphilis by, xvii, 11
Fournier's tooth, xvii, 223
Fourth disease, prevention undeveloped for, iv, 138
Fowler position, drainage after labor and, i, 97
— pyelitis of pregnancy and, i, 35
Fracastor, syphilis recorded by, xvii, 6
Fracture, birth, vi, 175
— — arm, i, 123
— — clavicular, i, 121, 123
— — femur, xv, 74
— — humerus, xv, 69
— — paralysis and, i, 127
— — treatment, illus., i, 123
— childhood, diagnosis of, vii, 156
— — occurrence of, vii, 155
— — repair of, vii, 155
— — treatment of, vii, 157
— — types of, vii, 155
— clavicle, iii, 296; vi, 161
— Colles', infancy and, xv, 95
— compound, xv, 116
— congenital, vi, 175
— elbow, vi, 156
— emergency treatment of, xv, 117
— femur, iii, 299; vi, 149
— forearm, vi, 151
— fragilitas ossium and, vi, 191; vii, 29
— general considerations of, vi, 147; xv, 66
— "greenstick," vii, 6
— growth and, xv, 2
— humerus, iii, 298; vi, 156, 158
— infants and management of, vii, 159

Fracture, intra-uterine, xv, 69
— jaw, xv, 181
— leukocytosis following, xx, 48
— malunited, vi, 169
— newborn bones subject to, vii, 154
— osteitis fibrosa cystica and, vi, 143
— osteogenesis imperfecta causing, vii, 29
— osteomalacia and, vi, 187
— osteopsathyrosis causing, vii, 29
— peripheral nerve injuries and, vi, 251
— postpartum, xv, 81
— Pott's, infancy and, xv, 116
— rachitic, scurvy differentiated from, vii, 211
— rickets predisposing to, vii, 193
— skull, iii, 294
— — cerebral compression in, xv, 161
— — cerebral irritation from, xv, 161
— — cerebral shock or concussion in, xv, 161
— — clinical features of, xv, 159
— — diagnosis of, xv, 162
— — general considerations of, xv, 157
— — pathology of, xv, 158
— — prognosis of, xv, 163
— — treatment of, xv, 158, 163
— spine, vi, 151
— — tuberculosis of spine differentiated from, vi, 91
— ununited, vi, 174
— — treatment of, vii, 158
— x-ray and, vi, 147
Fragilitas crinium, xvi, 254
Fragilitas ossium, vi, 49, 189
— characteristic lesions of, vii, 29
— clinical types and symptoms of, vii, 31
— diagnosis of, vii, 44
— etiology of, vii, 30; xiii, 165
— pathology of, vii, 41, 42
— symptoms of, vii, 30; xiii, 166
— synonyms of, xiii, 164
— treatment of, vii, 44; xiii, 167
— x-ray studies of, vii, 43
Freckles, symptoms of, xvi, 287
— treatment of, xvi, 288, 351
Free hydrochloric acid, ii, 87
French gonorrhea, xvii, 7
Frenulum linguæ, hemorrhage from, iii, 186
— operative relief of shortening of, iii, 130
Frenum, labial, Riga's disease of, viii, 12
— — simple ulcer of, viii, 12
— lingual, tongue-swallowing and, viii, 4
— — tongue-tie and, iii, 130; viii, 2
— ulcers of, treatment of, xv, 175
Frequency of respiratory infection during infancy, iv, 131
Freudian philosophy, v, 161
Friction, dermatitis caused by, xvi, 33
Friction fremitus, knee showing, vi, 13
Friction sounds, lobar pneumonia and, ix, 147
— significance of, ix, 98
Friedreich's ataxia, characteristics of, v, 70
— heredity and, iv, 8; v, 61
— orthopedic management of, vi, 250
Fright, acidosis in labor and, i, 131
— hyperglycemia and, xiii, 14
Fröhliche's syndrome, carbohydrate tolerance in, xiii, 85
— diagnosis of, xiii, 85
— infantilism and, x, 142; xiii, 147
— symptoms of, xiii, 77
— treatment of, xiii, 85
— type of obesity in, xiii, 79
Froin's syndrome, intraspinal tumors causing, xx, 116
Frontal bone, birth injuries of, i, 113
Frost-bite, Raynaud's disease differentiated from, xvi, 300
— treatment of, xvi, 37
Frozen milk, symptoms following use of, xii, 19
— vomiting in infancy and, viii, 95
Fruit, caloric value of, x, 193
— chemical content of, x, 289
— citrous, scurvy prevented by use of, x, 219, 227
— diet of pregnancy and, i, 23, 165
— normal child and, x, 123
— toxemias and, i, 37
— vitamin content of, x, 284

Fruit juices, bottle feeding supplemented by, xii, 131
Fulminating purpura, blood changes in, xx, 54
Functional absolute polycythemi, a case history of, xi, 216
Functional murmurs, types of, xviii, 196
Functional tests of kidney, xix, 36
Fungi, skin diseases due to, xvi, 173
Funicular hernia, iii, 160
Funnel-chest, vii, 50
Furrowed tongue, xvi, 341
Furunculosis, iii, 331
— alopecia following, xvi, 256
— etiology of, xvi, 217
— infection in newborn, ii, 119
— pathology of, xvi, 217
— prognosis of, xvi, 219
— scalp, xv, 154
— symptoms of, xvi, 217
— treatment of, xvi, 217
— typhoid fever and, viii, 190
— vaccination and, xiv, 114
Fusiform bacillus, Vincent's angina and, xx, 92

Gait, significance of, v, 12
Galactagogues, physiology of, xii, 169
Galen, vein of, v, 22, 46
Gall-bladder, diseases of, iii, 201
— newborn, iii, 129
Gall-duct, stenosis of, congenital syphilis causing, iii, 58
Gall-stones, iii, 204
— incidence of, viii, 328; xv, 333
Gallop sound of heart, xviii, 97
Games, hygiene and, iv, 85
Ganglia, basal, disorders of, v, 218
— — lenticular degeneration and, v, 71
— — muscle tone and, v, 1
— — symptoms of injury of, v, 49
— treatment of, vi, 215
Ganglion, vii, 264
Ganglion cells, congenital syphilis affecting, iii, 59
— pathology of, v, 215
Gangranose zahnkeimentzundung, iii, 191
Gangrene, bacteremia causing, i, 94
Gangrene, bronchopneumonia and, ix, 126
— foreign bodies in respiratory tract causing, ix, 191
— newborn, iii, 118
— peritonsillar abscess and, ix, 65
— pulmonary, characteristic appearance of sputum in, xx, 84
— — diagnosis of, ix, 183
— — etiology of, ix, 182
— — insufflation pneumonia causing, ix, 179
— — lobar pneumonia causing, ix, 160
— — pathology of, ix, 182
— — symptoms of, ix, 183
— — treatment of, ix, 183
— symmetrical, xvi, 299
— — late inherited syphilis and, xvii, 170
— umbilical, iii, 405
Gangrenous stomatitis, diagnosis of, viii, 33
— etiology of, viii, 31
— lesions of, viii, 32
— nomenclature of, viii, 30
— prophylaxis of, viii, 35
— symptoms of, viii, 32
— treatment of, viii, 34
Gargles, antiseptic solutions for, respiratory diseases and, ix, 262
Garré's sclerosing osteomyelitis, diagnosis of, vi, 141
— local manifestations of, vi, 139
— pathology of, vi, 139
— prognosis of, vi, 141
— symptoms of, vi, 139
— treatment of, vi, 141
Garters, pregnancy and, illus., i, 163
Gas, use during labor, ii, 123
Gaseous metabolism, ii, 95
Gas-oxygen, labor anesthesia of the tuberculous and, i, 29
Gastric acidity, importance of, xx, 90
Gastric alkalosis, loss of body chlorids causing, xiii, 36
Gastric contents, information derived from examination of, xx, 89
Gastric digestion, physiology of, viii, 89
Gastric hemorrhage, viii, 108

Gastric indigestion, birth injuries and, xii, 110
— chronic, treatment of, viii, 107
— diet and régime and, xii, 111
— food changes in, xii, 109
— meat in presence of milk causing, xii, 130, 134
— prematurity and, xii, 110
— prenatal causes of, xii, 109
— vomiting and, xii, 111-117
— weaning and, xii, 110
Gastric insufficiency, viii, 94
Gastric lavage, congenital pyloric stenosis and, iii, 144
— hematemesis and, iii, 186
— method of therapeutic use of, respiratory diseases and, ix, 271
Gastric stasis, vomiting and, xii, 115
Gastric ulcer, causes of, viii, 110
— hemorrhage from, iii, 183
— occurrence of, viii, 109
— pathology of, viii, 110
— symptoms of, viii, 111
Gastritis, acute catarrhal, pathology of, viii, 104
— — symptoms of, viii, 105
— acute toxic, symptoms and treatment of, viii, 106
Gastro-enterospasm, clinical description of, viii, 126
— diagnosis and differentiation of, viii, 128
— etiology of, viii, 126
— prognosis of, viii, 129
— symptoms of, viii, 127
— treatment of, viii, 127
Gastro-intestinal infection, infancy and, iv, 146
— malnutrition and, iv, 153
— prevention of, iv, 146
Gastro-intestinal system, development of, iii, 129
— developmental errors of, congenital diverticula, xv, 280
— — congenital volvulus, xv, 280
— — esophagus, xv, 272
— — intestines, xv, 275
— foreign bodies in, xv, 244
— functional disturbances of, iii, 171
— physiology of, ii, 82
— tuberculosis of, xiv, 352
Gatch bedspring, drainage cases and, i, 97
Gaucher's disease, blood-picture of, xi, 114; xx, 61
— diagnosis of, xi, 115
— discovery of, xi, 5
— history of, xi, 113
— pathology of, xi, 115
— physical signs of, xi, 114
— symptoms of, xi, 114
— treatment of, xi, 115; xv, 335
Gavage, breast feeding supplemented by, ii, 154
— method of therapeutic use of, respiratory diseases and, ix, 271
— prematurity and, ii, 181
— technic of, viii, 338
Gelatin, alimentary hemorrhage and, iii, 185
— hemorrhagic diseases of newborn and, ii, 239
General irradiation, effects of, x, 25
General paresis, rarity of, v, 81
General therapeutics of respiratory diseases, ix, 254
— actinotherapy in, ix, 260
— counterirritants in, ix, 256
— diet in, ix, 256
— drug therapy in, ix, 261
— heliotherapy in, ix, 260
— hydrotherapy in, ix, 259
— hygiene in, ix, 255
— management of patient in, ix, 255
— methods and technic in, ix, 267
— pharmaceutics in, ix, 261
— therapeutic methods in, ix, 267
Generalized extra-articular epiphysitis, vi, 146
Generalized scleroderma, xvi, 302
Generalized tuberculosis, diagnosis of, ix, 235
— incidence of, ix, 233
— prognosis of, ix, 236
— symptoms of, ix, 234
Gengou, work on syphilis by, xvii, 15
Genital hemorrhage, iii, 269
Genital tract, pregnancy and labor and, hygiene of, i, 95
— — lacerations and repair of, i, 97
Genitalia, anatomy of, iii, 259
— external, embryology of, xix, 6

Genitalia, female, diseases of, xix, 223
— — malformations of, iii, 263; xix, 222
— male, congenital anomalies of, iii, 260; xix, 211
— — diseases of, xix, 216
Genito-urinary system, anatomical considerations of, iii, 258; xix, 16
— diseases of, acute orchitis, xix, 216
— — amyloidosis, xix, 101
— — bacilluria, xix, 205
— — balanitis, xix, 219
— — balanoposthitis, xix, 219
— — bilateral hematogenous renal disease, xix, 75
— — chronic diffuse nephropathy, xix, 125
— — congenital anomalies of male genital organs, xix, 211
— — cystitis, xix, 207
— — diphtheria of vagina, xix, 229
— — diseases of male genital organs, xix, 216
— — diverticulum of bladder, xix, 203
— — ectopic testis, xix, 211
— — epididymitis, xix, 219
— — epispadias, xix, 214
— — erysipelas of vulva, xix, 229
— — exstrophy of bladder, xix, 198
— — gonococcal infection in female, xix, 225
— — hemorrhagic nephritis, xix, 101
— — hermaphroditism, xix, 223
— — hydrocele, xix, 212
— — hydronephrosis, xix, 193
— — hypospadias, xix, 213
— — infantile nephropathy, xix, 129
— — malformations and diseases of female genital organs, xix, 222
— — malignant tumors in region of kidney, xix, 183
— — malignant tumor of testis, xix, 218
— — methods of diagnosis of, xix, 34
— — narrowing of meatus, xix, 215
— — nephrosis, xix, 78
— — neuromuscular dysfunction of bladder, xix, 201
— — obstruction of urethra, xix, 215
— — paraphimosis, xix, 214
Genito-urinary system, diseases of, phimosis, xix, 214
— — precocious puberty, xix, 223
— — prolapse of bladder, xix, 205
— — renal stasis, xix, 128
— — rupture of kidney, xix, 193
— — simple vaginitis, xix, 228
— — stones in bladder, xix, 209
— — stones of the kidney, xix, 180
— — syphilis of kidney, xix, 192
— — syphilis of testis, xix, 218
— — tuberculosis of kidney, xix, 188
— — tuberculous orchitis, xix, 216
— — tumors of bladder, xix, 208
— — tumors of ovary, xix, 223
— — tumors of vagina, xix, 224
— — ulcerated meatus, xix, 220
— — urethritis, xix, 219
— embryology of, xix, 1
— — bladder and urethra, xix, 8
— experimental nephritis, xix, 24
— infections of, iii, 270
— — malnutrition and, iv, 153
— pathological physiology of, xix, 23
— physiology of, xix, 21
— roentgenograms of, preparation of patient for, xix, 44
— surgery of, adhesion of clitoris and prepuce, xv, 355
— — circumcision, xv, 353
— — congenital kidney anomalies, xv, 364
— — congenital stenosis of meatus, xv, 354
— — epididymis and testis, xv, 371
— — epispadias, xv, 359
— — exstrophy of bladder, xv, 357
— — general considerations of, xv, 349
— — hypospadias, xv, 355
— — phimosis, xv, 352
— — pyelitis, xv, 359
— — renal cysts, xv, 364
— — tuberculosis of kidney, xv, 365
— — tumors of kidney, xv, 366
— — tumors of testis, xv, 372
— — urinary lithiasis, xv, 362
— tuberculosis of, hematuria and, xix, 69
— tumors of, iii, 274
Genius, heredity and, v, 61

Gentian violet, acute infectious arthritis and, vi, 55
— gonorrhea treated with, i, 61
— staphylococcic puerperal infections treated with, i, 104
Genu recurvatum, description of, vi, 224
— diagnosis of, vii, 57
— orthopedic management of, vi, 287
Genu valgum, vii, 281
— definition of, vi, 185
— epiphyseal separation causing, vi, 166
— rickets causing, vi, 182
— treatment of, vi, 185
— tuberculosis causing, vi, 78
Genu varum, definition of, vi, 183
— rickets causing, vi, 182
— treatment of, vi, 185
Geographic tongue, viii, 15; xvi, 338
Gerhardt's ferric chlorid reaction for diacetic acid, xx, 10
Germ, maternal, theory of syphilis transmission by, xvii, 65
— paternal, theory of syphilis transmission by, xvii, 64
Germ-plasm, prenatal care and, i, 8
— syphilis transmitted by, i, 64
German measles, blood-count in, xi, 47
— complications of, xiv, 64
— definition of, xiv, 62
— diagnosis of, xiv, 66
— epidemiology of, xiv, 64
— erythema infectiosum differentiated from, xiv, 323
— erythema multiforme differentiated from, xvi, 62
— etiology of, xiv, 62
— history of, xiv, 62
— incubation period of, xiv, 63
— leukocyte count in, xx, 47
— measles differentiated from, xiv, 48
— newborn and, iii, 28
— prognosis of, xiv, 67
— Public Health regulations for, xiv, 67
— scarlet fever differentiated from, xiv, 18
— symptoms of, xiv, 63
— synonyms of, xiv, 62
German measles, treatment of, xiv, 67
Gesell's time tables, iv, 79
— mention of, v, 49
Gestation, abnormalities of, i, 17
— abscesses in, i, 35, 88
— accidents of, maternal death-rate in, i, 4
— acidosis in, i, 130, 131
— after-care of, i, 28
— albuminuria in, i, 4, 21, 35, 37, 38, 49
— asepsis of, i, 86, 95, 96
— blood-pressure and, i, 22, 160, 162
— breast hygiene in, i, 141, 157
— civic protection of mothers during, i, 17, 155
— clothes for, i, 162
— constipation during, i, 166
— convalescence and, i, 160
— cysts and, ovary, i, 41
— danger signals of, i, 168
— deaths due to, maternal, i, 2, 5
— diet of, i, 22-25, 164
— digestion and, i, 24
— ectopic, secondary shock and, i, 133
— examination of, i, 17-22, 160
— exercise during, i, 168
— — corrective, i, 160, 161
— gonococcal infection during, i, 88
— — treatment of, i, 61, 62
— growth variations and length of, iv, 16
— heart disease and, i, 29-34
— hemorrhage in, i, 50
— — calcium in prevention of, i, 139
— hygiene of, i, 28, 95, 156
— instructions and, labor, i, 160, 161, 170
— intestinal care and, i, 25
— kidney conditions and, i, 21, 166
— legislation regulating employment during, i, 156
— liver conditions of, i, 21
— maternal occupation and, iv, 16
— medical complications of, i, 25-62
— menstruation periods during, i, 162
— miscarriages, prevention of, i, 162
— mitral stenosis and, i, 30, 32
— nausea of, i, 25, 26, 168
— nervous disorders and, prenatal care in, i, 39-41

Gestation, nipples in, care of, i, 141
— placenta prævia and, i, 56-61
— postural treatment in, i, 19, 20, 35, 161, 168
— psychoses and, i, 39, 107, 169
— pyelitis and, i, 34-36
— pyelonephritis and, i, 35
— rest during, i, 21, 24, 32, 46, 47, 142, 161, 162, 167
— skin during, care of, i, 167
— supervision plan during, i, 17, 161, 169, 170
— supplies for, i, 170
— syphilis in, i, 63-84
— teeth during, care of, i, 166
— termination of, i, 18, 47
— — cardiac disease and, i, 31, 33
— — nervous disorders and, i, 40
— — pyelitis and, i 36
— — syphilis and, i, 79
— — tuberculosis and, i, 28, 80-84
— toxemias of, abruptio placentæ and, i, 52
— — acidosis with, 130-133
— — chronic, high blood-pressure in, i, 22
— — convulsions and, i, 10
— — death in utero caused by, i, 107
— — fetal death and, i, 9, 48
— — intestinal care and, i, 25
— — maternal deaths due to, i, 4, 5, 11
— — nausea and vomiting in, i, 25
— — placental separation and, i, 55
— — premature labor induction in, i, 107, 131
— — prenatal care and, i, 10, 11, 15, 16, 36-39, 150
— — puerperal infections due to, i, 91
— — shock at labor caused by, i, 130, 131
— — syphilis and, i, 75, 80
— — Wassermann reaction in, i, 76
— tuberculosis and, i, 26-29
— — treatment, i, 27
— tumors and, ovary, i, 41
— urinalysis and, i, 21, 160, 162
— uterine myomata and, i, 42
— vaginal smear and, i, 160
— varicose veins and, i, 157, 168
Gestation, Wassermann reaction in, i, 76, 77, 160
— — chart, i, 69
— weight and height of newborn and length of, x, 92
— weight during, i, 24
Giant-celled bone tumors, diagnosis of, vi, 196
— occurrence of, vi, 194
— pathology of, vi, 195
— treatment of, vi, 196
Giant urticaria, xvi, 76
Giardia intestinalis, infestation with, viii, 309
Giardia lamblia, morphology and identification of, xx, 78
Gibney adhesive sprain dressing, vi, 119
Gigantism, Fröhlich's syndrome and, x, 144
— hyperpituitarism and, xiii, 22
Ginger ale, nausea and, i, 25
Gingivitis, viii, 13
Glabrous skin, ringworm of, xvi, 177
— — diagnosis of, xvi, 182
— — treatment of, xvi, 188
Glanders, blood-count in, xi, 47
Glands, endocrine, adrenal, xiii, 92
— — gonads, xiii, 95
— — interrelation of, xiii, 106
— — pancreas, xiii, 99
— — parathyroid, xiii, 71
— — pineal, xiii, 74
— — pituitary, xiii, 76
— — thymus, xiii, 87
— — thyroid, xiii, 44
— lacrimal, Mikulicz' disease affecting, viii, 55
— mammary, anatomy of, ii, 139; xii, 156
— — physiology of, xii, 156
— Montgomery's, ii, 139
— salivary, abnormal development of, viii, 53
— — absence of, viii, 54
— — anatomical and functional considerations of, viii, 52
— — cyst of, viii, 54
— — disturbances of secretion of, viii, 53
— — epidemic infection of, viii, 56

Glands, salivary, lymphatic enlargement affecting, viii, 59
— — Mikulicz' disease of, viii, 55
— — non-epidemic parotitis, viii, 56
— — stones obstructing ducts of, viii, 58
— — syphilis affecting, viii, 59
— sublingual, inflammation of, viii, 58
— submaxillary, inflammation of, viii, 58
Glandular fever, ix, 44
— blood changes in, xiv, 316; xx, 55
— definition of, xiv, 314
— diagnosis of, xiv, 317
— etiology of, xiv, 314
— history of, xiv, 314
— incubation period of, xiv, 317
— occurrence of, xiv, 316
— pathology of, xiv, 315
— prognosis of, xiv, 318
— symptoms of, xiv, 317
— synonyms of, xiv, (308), 314
— treatment of, xiv, 318
Glaucoma, congenital, iii, 357
Gliosarcoma, cerebral, iii, 250
Globulin, ii, 48
— amount present at birth, ii, 111
— cerebrospinal, neurosyphilis and, xvii, 54
— — normal, xx, 98
— — test for, v, 16
— serum and plasma, significance of, xx, 130
— tuberculous meningitis and, v, 97
Globus pallidus, v, 71
Glomerular (hemorrhagic) nephritis, acute, acidosis in, xx, 173
— — blood chemistry in, xx, 138
— — clinical symptoms of, xx, 136
— — kidney function in, xx, 138
— chronic, blood chemistry in, xx, 150
— — clinical features of, xx, 148
Glomerulitis, mild focal, clinical symptoms of, xx, 136
— severe diffuse, clinical features of, xx, 136
Glomerulonephritis, acute focal, hematuria caused by, xix, 69
— diffuse, course of, xix, 114
— — diagnosis of, xix, 118
Glomerulonephritis, diffuse, pathologic changes in, xix, 107
— — symptoms of, xix, 108
— — treatment of, xix, 119
— — treatment of uremia in, xix, 124
— embolic non-purulent, xix, 106
— focal, course of, xix, 103
— — symptoms of, xix, 102
— — treatment of, xix, 103, 106
Glomerulotubular nephritis, acute mixed, blood chemistry of, xx, 143
— — clinical features of, xx, 143
Glossitis, viii, 16, 17
— erythematous marginal, iii, 189
Glottis, edema of, ix, 83; xiv, 148, 151
— spasm of, tetany and, x, 250
Glucose, acidosis treated by use of, x, 273
— intravenous administration of, diffuse glomerulonephritis and, xix, 120
— prematurity and, ii, 183
— spinal fluid, neurosyphilis and, xvii, 54
— transfusion of, icterus neonatorum and, ii, 226
Glucose hypodermoclysis, dehydration and, xv, 22
Glucose injections, rectal, toxemias and, i, 37
— intravenous, nausea and, i, 26
— — toxemias and, i, 131
Gluteal dermatitis, hereditary syphilitic lesions differentiated from, xvii, 244
Gluteal erythema, xvi, 35
Glycocholic acid, ii, 92
Glycocoll, ii, 106
Glycogen, amount in newborn, ii, 48
— carbohydrate and, x, 16
— effect on respiratory quotient, ii, 96
— metabolism of, xiii, 13
Glycosuria, alimentary, diabetes mellitus differentiated from, xiii, 103
— cause of, xiii, 14
— diabetes mellitus and, xiii, 101
— — treatment of, xiii, 104

Glycosuria, outline of work-up for cases of, xx, 164, 165
— significance in newborn, xx, 3, 8
— whooping-cough and, xiv, 126
Goat's milk, chemical composition of, xii, 10, 19
Gobbling of food, xii, 139, 154
Goiter, acquired, surgery of, xv, 200
— congenital, iii, 382
— exophthalmic, prematurity caused by, ii, 163
— — prognosis of, xiii, 49
— — symptoms of, xiii, 47
— — telangiectasia in, xvi, 295
— — tests of thyroid function in, xiii, 48
— — thymus in, xiii, 92
— — treatment of, xiii, 49
— pubescence showing increase in, iv, 121, 125
— school age, iv, 125
— simple, incidence of, xiii, 45
— — iodin and, iv, 125
— — preventive pediatrics and, iv, 125
— — prophylaxis of, xiii, 46
— — treatment of, xiii, 47
Golf, pregnancy and, i, 24
Gonads, disease involving, eunuchism, xiii, 95
— — mumps, xiii, 97
— — precocious sexual development, xiii, 99
— female, xiii, 97
Gonococcal infection, female genital organs and, xix, 225
Gonococcus, acute infectious arthritis and, vi, 50
— conjunctivitis and vaginitis caused by, xx, 93
— meningitis caused by, xx, 106
Gonococcus infection, newborn and, iii, 30
Gonorrhea, pregnancy with, i, 88
— abortion and, i, 45
— premature labor contraindicated in, i, 106
— prenatal care in, i, 15, 16
— symptomatology of, i, 94
— treatment of, i, 61, 62
Gonorrheal arthritis, iii, 308
Gonorrheal arthritis, acute, acute rheumatic fever differentiated from, vii, 97
— — Still's disease differentiated from, vii, 105
Gonorrheal ophthalmia neonatorum, iii, 364
Gonorrheal proctitis, treatment of, viii, 292
Gonorrheal stomatitis, iii, 189
Gonorrheal vulvovaginitis, iii, 271
— malnutrition and, x, 188
Grafts, bone, age of child and, vi, 176
— — homogenous, congenital fractures and, vi, 176
— — massive, congenital fractures and, vi, 177
— — — ununited fractures and, vi, 174
— skin, scar prevention and, vi, 203
— — scar treatment by, vi, 204
— — types of, vi, 205
Graham, Evarts, theory of hemorrhagic disease, ii, 232
Grain itch, xvi, 159
Grains, vitamin content of, x, 284
Grand mal epilepsy, significance of, v, 138
Granular leukocytes, formation and origin of, xi, 18
— morphology of, xi, 16
— oxidase stain and, xi, 29
Granuloma, infectious, xvi, 196
— laryngeal, iii, 72
— umbilical, iii, 408
Granuloma annulare, diagnosis of, xvi, 240
— etiology of, xvi, 240
— prognosis of, xvi, 241
— symptoms of, xvi, 240
— treatment of, xvi, 240
Granuloma pyogenicum, diagnosis of, xvi, 221
— etiology of, xvi, 221
— pathology of, xvi, 221
— prognosis of, xvi, 222
— symptoms of, xvi, 220
— treatment of, xvi, 221
Granulosis rubra nasi, diagnosis of, xvi, 278
— etiology of, xvi, 278

Granulosis rubra nasi, pathology of, xvi, 278
— prognosis of, xvi, 279
— symptoms of, xvi, 278
— treatment of, xvi, 279
Grapefruit, diet of pregnancy and, i, 165
Graves' disease, pregnancy and, i, 6, 18
— prognosis of, xiii, 49
— symptoms of, xiii, 47
— tests of thyroid function in, xiii, 48
— thymus in, xiii, 92
— treatment of, xiii, 49
Gray hair, etiology of, xvi, 263
— incidence of, xvi, 262
Gray patch ringworm, xvi, 174
Green soap, vaginal examination and, i, 160
Greenstick fracture, xv, 66
Gregariousness, preventive pediatrics and, iv, 70
Grenouillette, definition of, viii, 54
Grip, synonyms of, xiv, 379
Grossflechen, synonyms of, xiv, 320
Grotthus' law, vii, 219
Ground itch, xvi, 171
Group medicine, rural, i, 159
— midwifery and, i, 154
Grouped comedones, xvi, 279
Grouping, blood-, xx, 42
— — classification of, xi, 30
— — technic of, xi, 32
Growing pains, rheumatic infection and, xviii, 72
— tonsillectomy and, ix, 60
Growth, abnormal, dwarfism, xiii, 147
— — exogenous obesity, xiii, 137
— — fragilitas ossium, xiii, 164
— — infantilism, xiii, 145
— — Lorraine infantilism, xiii, 145
— — malnutrition, xiii, 139
— — microcephalus, xiii, 164
— — mongolism, xiii, 153
— — obesity, xiii, 137
— — osteomalacia and osteogenesis imperfecta, xiii, 164
— — osteopsathyrosis, xiii, 164
— — progeria, xiii, 162
— — true infantilism, xiii, 145
Growth, albuminuria resulting from, xix, 60; xx, 7
— caloric value of food and, x, 214
— carbohydrates and, x, 16, 34
— catalyzers of, iv, 14
— chest measurements to ten years, iv, 30
— cycles of acceleration in, iv, 14
— definition of, x, 51, 78
— endocrine influence on, x, 88; xiii, 21
— factors influencing, iv, 14
— factors responsible for, x, 78
— fevers affecting, xiii, 22
— food and, xiii, 20
— head measurements to ten years, iv, 30
— height, weight and development, iv, 28
— height-weight standard of, xiii, 19
— heredity and, ii, 44; xiii, 19
— human ovum, x, 43
— infant and child feeding and, xii, 7
— intercurrent disease affecting, xiii, 22
— locomotion and, iv, 66
— measurements of, iv, 29
— mental, preventive pediatrics and, iv, 65
— metabolism and, xiii, 6
— normal infancy gain in, iv, 24
— normal variation in size, iv, 16
— periods of greatest, xiii, 7, 17
— prematurity and increased rate of, xii, 100, 102
— prenatal, x, 42
— preschool, iv, 19, 20, 25
— preventive pediatrics and, iv, 14
— proportions at different ages, iv, 30; x, 79, 86
— protein and, x, 11; xii, 52, 66
— pubescence and, iv, 26
— quotient of, ii, 39
— race influencing, iv, 28
— school age, iv, 22, 25
— seasonal variation in rate of, xiii, 18
— sex and, ii, 42; xiii, 18
— speech and, iv, 66
— standards for measurement of, xiii, 18

Growth, statistics covering infancy and, iv, 16
— successful nursing and, xii, 184
— sunshine and, x, 25
— surgical prognosis and, xv, 2
— teeth eruption, iv, 31
— variation in, iv, 27
— vitamin A promoting, x, 22
— vitamin B and, x, 23
— vitamins and, x, 21, 214
— weight at birth and, x, 79
— weight-height table (birth to three years), x, 80
Growth quotient, newborn, ii, 39
Grunting respiration, significance of, ix, 89
Gubernaculum testis, development of, xix, 3
Guernsey cows, milk from, xii, 13
Gum-acacia emulsion, placenta prævia cases treated with, i, 61
Gum glucose, infusion apparatus for, illus., i, 135
— transfusion of, shock following labor and, i, 135
Gummata, bone, late inherited syphilis and, xvii, 157
— cerebral, neurosyphilis and, xvii, 206
— — treatment of, xvii, 281
— congenital syphilis and, iii, 59
— mucous membrane, hereditary syphilis and, xvii, 249
— pathology of, xvii, 33
— skin, hereditary syphilis and, xvii, 248
— soft parts involved by, late inherited syphilis and, xvii, 164
— syphilitic, erythema induratum differentiated from, xvi, 236
— — erythema nodosum differentiated from, xvi, 64
— — multiple abscesses of infancy differentiated from, xvi, 219
— visceral, pathology of, xvii, 37
Gums, abscess of, viii, 13
— diseases of, viii, 13
— hypertrophy of, viii, 14
— periostitis of, viii, 13
— scurvy of, viii, 14
Gynecology, teaching, i, 150
Habits, v, 199
— constipation and, xii, 125
— deviations from normal due to, iv, 4
— feeding, normal child's, x, 121
— food, iv, 74
— food requirements and, xii, 97
— formation of, iv, 67, 72, 73
— infant, regulation of, i, 174
— thumb sucking, psychology of infancy and, xii, 153
— — vomiting caused by, xii, 114
Habit-spasms, v, 206
— adenoids and, ix, 70
— chorea differentiated from, xviii, 61
— fear causing, iv, 72
Habitual constipation, hygiene and, iv, 90
Habitus septicus, iii, 15
Hair, color of, heredity and, iv, 8
— diseases of, alopecia areata, xvi, 257
— — alopecia congenita, xvi, 252
— — alopecia symptomatica, xvi, 255
— — atrophia pilorum propria, xvi, 253
— — canities, xvi, 262
— — fragilitas crinium, xvi, 254
— — hypertrichosis, xvi, 251
— — monilethrix, xvi, 254
— — ringed hair, xvi, 263
— — trichorrhexis nodosa, xvi, 254
Haldane hemoglobin scale, mention of, ii, 203
Hands, acute infectious arthritis of, vi, 67
— postpartum fractures of, xv, 102
— ringworm of, xvi, 178
— scar contractures of, vi, 207
— swelling of, pregnancy and, i, 168
Hard palate, ulceration of, viii, 35
Harelip, breast feeding and, ii, 155; iii, 134
— cause of, iii, 131
— disfiguration from, viii, 6
— effect upon health, viii, 7
— embryology of, xv, 166
— etiology of, vii, 54; xv, 167
— feeding problems in, iii, 134
— latent syphilis and, xvii, 231
— malnutrition and, iv, 152

Harelip, nursing and, iv, 48
— nutritional care of, vii, 54
— occurrence of, viii, 6
— pathology of, iii, 131
— prognosis of, viii, 10
— symptoms of, iii, 133
— treatment of, iii, 133; vii, 55; viii, 10; xv, 168
— when to operate upon, viii, 8
Harlequin fetus, iii, 336; xvi, 16
Harrison's groove, rickets and, vi, 182; x, 237
Harvard posture studies, vii, 266
Harvest mite, xvi, 168
Haversian canals, formation of, vii, 3
Hay-fever, ix, 117
— susceptibility and, viii, 317
Head, average birth measurements of, ii, 20
— caput succedaneum of, ii, 24
— cephalematoma, ii, 24
— circumference of, normal, v, 188
— — relation of age to, ii, 162
— cold in, ix, 1
— congenital malformations of, xv, 151
— — clinical features of, xv, 152
— congestion of, ii, 24
— deformities of, iii, 280
— development of, x, 52, 73
— edema of, ii, 24
— fetal, breech delivery and, i, 117, 121
— — diagrams, illus., i, 115
— — injuries at birth to, i, 112, 113, 121
— — pelvis and, i, 128
— — position of, i, 96
— — toxemias and, i, 37
— hot-cross bun, vii, 142
— local injuries of, xv, 164
— measurements of, iv, 30; vii, 7
— molding of, ii, 24
— newborn characteristics of, ii, 10
— orthopedic apparatus for, vi, 39
— proportionate size of, ii, 21, 23
— race affecting size of, ii, 20
— retraction of, neurosyphilis and, xvii, 186
— shaping of, ii, 32
Head, special differences between adult and infant, vii, 6
— surgery of, congenital malformations, xv, 151
— — local injuries, xv, 164
— — scalp, xv, 152
— — skull fractures, xv, 157
Headache, accessory nasal sinus disease and, ix, 28
— asthma and, ix, 112
— brain tumors causing, v, 18, 117
— meningitis causing, v, 85
— tonsillitis causing, ix, 52
Head and chest measurement in infancy, iv, 30
Head-louse, xvi, 155
Health, posture and, iv, 35
— Public, baby stations for, i, 156
— — prenatal care and, i, 149-175
— — rural centers for, i, 159
Health alphabets, education and, iv, 100
Health education, hygiene and, iv, 100
— school age, iv, 100
Health songs, hygiene and, iv, 100
Hearing, degree at birth, ii, 115
— early characteristics of, ii, 7
Heart, abnormalities of orifices of, iii, 107
— accentuation of sounds of, xviii, 96
— action of, determination of, xviii, 93
— acute dilatation of, iii, 105
— acute illness and, xviii, 190
— anatomical considerations of, xviii, 129
— anomalies of, chambers of, iii, 105
— — classification of, xviii, 130
— — position of, iii, 104
— — veins of, iii, 112
— — vessels of, iii, 110
— auricular fibrillation of, xviii, 95
— bilocular, iii, 105
— broken compensation of, breast feeding prevented by, ii, 150
— Buhl's disease causing fatty degeneration of, iii, 4
— combined lesions of, anatomical considerations of, xviii, 133
— — clinical aspects of, xviii, 143

Heart, congenital heart-block, iii, 110
— congenital malformations of, xviii, 4
— — anatomical considerations of, xviii, 129
— — classification of, xviii, 130
— — clinical varieties of, xviii, 138
— — electrocardiographic determination of, xviii, 184
— — mongolism and, xiii, 157
— congenital stenosis and atresia of aortic orifice, iii, 108
— congenital syphilis affecting, iii, 58
— development of, x, 70, 74, 77; xviii, 129
— dilatation of, diagnosis of, xviii, 199
— diminution of sounds of, xviii, 96
— diphtheria and, xviii, 191
Heart, disease of, abruptio placentæ and, i, 52
— — acute bronchitis and, ix, 102
— — after-effects of, i, 33
— anemia caused by, xx, 50
— — diffuse glomerulonephritis and, xix, 110
— — history and, patient's, i, 17
— — icterus index in, xx, 40
— — pregnancy and, i, 6, 29-34
— — prematurity caused by, ii, 163
— — prenatal care and, i, 31, 32
— — tachycardia distinguished from, i, 33
— — tonsillectomy and, ix, 60
— — treatment of, i, 31
— — tuberculosis causing, relative frequency of, ix, 231
— — urobilinuria in, xx, 11
— electrocardiography, ii, 59; xviii, 165
— examination of, xviii, 90
— fetal, condition of, ii, 123
— first sound of, xviii, 95
— functional disorders of, xviii, 5
— gallop sound of, xviii, 97
— hematomata of valves of, iii, 109
— hypertrophy of, diagnosis of, xviii, 199
— hypoplasia of, iii, 112
— idiopathic congenital hypertrophy of, iii, 105
Heart, interauricular septal defects of, xviii, 131
— interventricular septal defects of, xviii, 130, 140
— mongolism and congenital disease of, v, 189
— — murmurs of, factors to be noted about, xviii, 97
— — table of terms for description of, xviii, 100
— nephritis and, xviii, 193
— newborn, anatomy of, iii, 100
— — defects of interauricular septa, iii, 106
— — defects of interventricular septum of, iii, 107
— — dimensions of, iii, 100
— — diseases of, iii, 103
— — disturbances of controlling and conducting mechanism of, iii, 109
— — growth of, iii, 102
— — location of, iii, 100
— — measurements of, iii, 102
— — patent foramen ovale, iii, 106
— — primary hypertrophy of, iii, 105
— — pulmonary atresia and stenosis, iii, 107
— — relations of, iii, 101
— — thickness of walls of, iii, 100
— — weight of, iii, 100
— normal physiology of, xviii, 42
— pacemaker of, xviii, 172
— patent ductus arteriosus of, xviii, 133, 142
— pectoral, iii, 104
— pneumonia and, xviii, 190
— premature contractions of, xviii, 95
— P-R interval of, ii, 62
— pulmonic stenosis of, xviii, 133
— pulse rate in newborn, ii, 55
— Q-R-S interval, xviii, 166
— Q-R-T interval of, ii, 63
— rare defects of, xviii, 145
— rate, force and rhythm of, determination of, xviii, 93
— reflexes affecting, later childhood and infancy and, xii, 140
— rheumatic fever and pathology of, xviii, 21
— rheumatic infection of, xviii, 63

Heart, right-sided, anatomical considerations of, xviii, 136
— Roger's disease of, iii, 107
— scarlet fever and, xviii, 192
— scurvy causing enlargement of, vii, 203
— second sound of, xviii, 95
— septal defects of, iii, 106; xviii, 130
— — clinical aspects of, xviii, 140
— septicemia and, xviii, 193
— shape of, x-ray determination of, xviii, 151
— single lesions of, xviii, 130, 139
— size of child affected by maternal disease of, ii, 14
— size of, determination of, xviii, 91, 147, 149
— sounds of, study of, xviii, 95
— — table of terms for description of, xviii, 100
— syphilis of, pathological evidence of, xvii, 31, 37
— systematic study of, xviii, 90
— third sound of, xviii, 97
— thrills of, significance of, xviii, 103
— transmission time, ii, 62
— transportation of great vessels of, iii, 111
— typhoid fever and, xviii, 192
— variations in rate due to age, ii, 55
— waves, *P, Q, R, S,* and *T* described, ii, 59
— x-ray examination of, xviii, 147
Heartbeat, functional changes in, electrocardiographic determination of, xviii, 170
— mechanism of, xviii, 43
Heart-block, complete, diagnosis of, xviii, 200
— congenital, iii, 110
— partial and complete, electrocardiographic determination of, xviii, 175
— pathological physiology of, xviii, 48
Heart disease, acquired, newborn, iii, 117
— — preventive pediatrics and, iv, 126
— age incidence of deaths from, xviii, 213
Heart disease, causes of, xviii, 1
— classification of, functional, xviii, 201
— clinics for, organization and administration of, xviii, 231
— — source of patients of, xviii, 230
— congenital, iii, 103
— — clinical varieties of, xviii, 138
— — malnutrition and, iv, 152
— — unpreventability of, iv, 126
— convalescent homes for, xviii, 234
— coöperating agencies for, xviii, 233
— diagnosis of, anatomical, xviii, 195, 238
— — etiological, xviii, 194, 237
— — examination in, xviii, 90
— — functional, xviii, 200, 241
— — nomenclature for, xviii, 237
— — physiologic, xviii, 199, 239
— effort syndrome in, xviii, 85
— estimated prevalence of, iv, 127
— familial tendency to, iii, 104
— forms of, xviii, 4
— functional classification of, xviii, 201
— malnutrition and, iv, 160
— methods of study of, history taking, xviii, 74
— morbidity of, xviii, 2
— mortality of, xviii, 1
— organized clinics for, xviii, 2
— physical signs of, aortic insufficiency, xviii, 120
— — aortic stenosis, xviii, 122
— — methods of recording, xviii, 105
— — mitral insufficiency, xviii, 114
— — mitral stenosis, xviii, 116
— — pericardial effusion, xviii, 125
— — pericarditis, xviii, 124
— — pulmonary signs, xviii, 126
— — tricuspid insufficiency, xviii, 123
— prevention of, xviii, 226
— prognosis of, xviii, 206
— pubescence showing increase in, iv, 121
— relative mortality of heart disease and, xviii, 3
— rheumatic, infection causing, xviii, 3
— — *See also* Rheumatic heart disease, xviii.

Heart disease, symptoms of, xviii, 79
— systematic care of children with, xviii, 229
— treatment of, xviii, 214
Heart-failure, congestive, rheumatic infection and, xviii, 86
— symptoms of, xviii, 48
— — pregnancy and, i, 30
— treatment of, xviii, 218
Heart lesions, newborn and, i, 137
Heart murmurs, pregnancy and, i, 30, 31
Heart stimulants, lobar pneumonia and, ix, 166
Heat, carbohydrate supplying, x, 16
— counterirritant use of, respiratory diseases and, ix, 257
— daily caloric loss in newborn, ii, 38
— dermatitis caused by, xvi, 33, 36
— fats producing, xii, 45
— height and weight and total output of, xiii, 6
— incubators and, ii, 179
— milk preparation and, xii, 16, 19
— perspiration and, ii, 109
— prematurity and maintenance of, ii, 177
— sensation present at birth, ii, 115
— sex and total output of, xiii, 7
— sweat influencing, ii, 109
Heat center, ii, 50
Heat exhaustion, infancy and, viii, 102
Heat rash, iii, 349
Heat stroke, dehydration and, xiii, 41
Hebra's salve, xvi, 351
Heel, scar contractures of, vi, 209
Height, age and, x, 83, 84
— age and weight tables, iv, 17
— boys and girls (4 years to 16 years), x, 81
— excessive, cause of, x, 146
— factors influencing, x, 86
— heredity and, iv, 10
— importance of weight comparisons with, iv, 29
— inanition and, x, 212
— increment at different ages, iv, 21
— metabolism and, xiii, 8
— seasonal factor in, x, 88
Height, weight, age table, pubescent, iv, 22, 23
— — — school age, iv, 22, 23
— weight and development and, iv, 28
Height-weight, age and, xiii, 6
— average (boy) tables of, x, 111, 112
— average (girl) tables of, x, 113, 114
— birth to three years, x, 80
— boys (6 years to 18 years), x, 82
— girls (6 years to 18 years), x, 82
— growth measured by, xiii, 19
— total heat output and, xiii, 6, 8
Heine-Medin disease, vii, 240
— synonyms of, xiv, 224
Held milk, growth and, xii, 17
Heliotherapy, action of light on pathogenic microörganisms, vii, 218
— anemia secondary to infectious diseases and, xi, 77
— anemia secondary to malnutrition and, xi, 69
— application to diseases of bones and joints, vii, 221
— — indications for, vii, 222
— — practice of, vii, 223
— chronic infectious arthritis and, vi, 106
— composition of light, vii, 217
— coxa plana and, vi, 110
— enlarged non-tuberculous bronchial glands and, ix, 211
— foot and ankle tuberculosis and, vi, 76
— Grotthus' law and, vii, 219
— influence of local conditions on sunlight, vii, 218
— joint tuberculosis and, vi, 72
— physiology of photochemical action, vii, 220
— psoriasis and, xvi, 133
— respiratory diseases and, ix, 260
— rickets and, vi, 182; vii, 227; xiii, 118
— Rollier's technic in surgical tuberculosis, vii, 223
— sunlight and artificial light compared, vii, 219
— tuberculosis and, xiv, 365

Hemangioma, xvi, 4
— facial, surgery of, xv, 173
— parotid, viii, 53
— surgical aspects of, xv, 57
Hematemesis, iii, 183
— epistaxis differentiated from, ix, 19
Hematidrosis, xvi, 276
Hematoblasts, characteristics of, xi, 12
— significance of, xi, 15
Hematocele, iii, 263
Hematocrit reading of blood, xx, 31, 33
Hematogenous renal disease, bilateral, amyloidosis and, xix, 101
— — chronic diffuse nephropathy and, xix, 125
— — edema as a symptom of, xix, 75
— — hemorrhagic nephritis and, xix, 101
— — infantile nephropathy, xix, 129
— — nephrosis and, xix, 78
— — renal stasis, xix, 128
Hematoma, forceps deliveries and, i, 125
— heart valves showing, iii, 109
— nasal, epistaxis causing, ix, 19
— peripheral nerve injury and, vi, 251
— scalp and, xv, 153
Hematomyelia, dissociation of sensation in, v, 216
Hematopoietic cells, liver of syphilitic infants and, i, 74, 75
Hematopoietic system, blood-pictures in diseases outside of, xi, 47, 50, 53
— blood-platelets, xi, 21
— diseases of, acute lymphatic leukemia, xi, 133
— — acute myelogenous leukemia, xi, 150
— — anemias associated with disturbances of spleen and lymph-nodes, xi, 98
— — anemia due to blood destruction, defective formation, or both, xi, 63
— — chloroma, xi, 169
— — chronic lymphatic leukemia, xi, 143
— — chronic myelogenous leukemia, xi, 156
Hematopoietic system, diseases of, functional absolute polycythemia, xi, 216
— — hemophilia, xi, 182
— — hemorrhagic disease of newborn, xi, 177
— — historical résumé of, xi, 1
— — idiopathic anemias, xi, 98
— — idiopathic non-thrombopenic purpura, xi, 205
— — idiopathic purpura hæmorrhagica, xi, 190
— — leukemias, xi, 129
— — leukemias without leukocytosis (aleukemic or aleukocytic), xi, 161
— — non-thrombopenic purpura, xi, 204
— — polycythemia, xi, 215
— — primary absolute polycythemia, xi, 218
— — primary anemias, xi, 85
— — purpura, xi, 189, 191
— — relative polycythemia, xi, 215
— — secondary anemia, xi, 59
— — secondary non-thrombopenic purpura, xi, 209
— — secondary (symptomatic) thrombopenic purpura, xi, 201
— — thrombopenic purpura, xi, 190
— erythrocytes, xi, 11
— importance of, xi, 5
— leukocytes, xi, 16
— reaction to stimuli during infancy and childhood, xi, 21
Hematoporphyrin, x, 25
— hydroa vacciniforme and, xvi, 97
Hematoporphyrinuria, causes of, xix, 67
— significance of, xx, 10
Hematuria, asthma and, ix, 112
— causes of, xix, 69
— congenital and familial, xix, 70
— essential, xix, 70
— scurvy and, xiii, 121
— significance of, xx, 13
Hemicrania, anatomy of, vii, 53
Hemimelia, iii, 283
Hemiplegia, chorea resembling, xviii, 59
— congenital syphilis and, v, 83

Hemiplegia, neurosyphilis clinically manifested by, xvii, 191
Hemoglobin, abruptio placentæ and, i, 56
— age and possible variation in percentage of, xi, 38
— amount in 100 c.c. of blood from birth to fifteen years, xx, 26
— color index and, ii, 65
— determination of, xi, 25
— functions of, xi, 6
— hemorrhagic disease affecting, ii, 236
— influence of race upon, xx, 27
— methods of estimating, xx, 27
— newborn showing decrease in, ii, 213
— percentage equivalents according to various standards, xx, 28
— physiological considerations of, ii, 64
— prematurity and, ii, 166
Hemoglobinuria, etiology of, xix, 68
— late inherited syphilis and, xvii, 169
— significance of, xx, 11
— symptoms of, xix, 68
Hemolytic anemia, familial, blood changes in, xx, 59
— icterus index in, xx, 40
— urobilin in, xx, 11
Hemolytic jaundice, blood changes in, xx, 61
— case history of, xi, 116
— character of stools in, xx, 74
— characteristics of, xi, 116
— diagnosis of, xi, 119
— familial, case history of, xi, 116
— first description of, xi, 5
— hereditary, ii, 224
— surgical aspects of, xv, 54
— symptoms of, xi, 118
— treatment of, xi, 120
— urobilin in, xx, 11
Hemolytic organisms, bacteriemia and, i, 94
Hemolytic streptococci, scarlet fever and, iv, 136, xiv, 11
Hemopericardium, Winckel's disease and, iii, 2
Hemophilia, adenoidectomy contraindicated in, ix, 74
Hemophilia, blood changes in, xi, 185; xx, 52
— blood-count in, xi, 184
— case history of, xi, 183
— course of, xi, 187
— diagnosis of, xi, 186
— epistaxis and, ix, 18
— etiology of, xi, 182
— first description of, xi, 3
— marriage and, iv, 10
— mendelian aspects of, v, 61
— Nasse's law, xi, 3
— newborn and, i, 138
— — treatment, i, 139
— pregnancy with, calcium medication for, i, 23
— purpura hæmorrhagica differentiated from, viii, 274; xvi, 70
— sex-linked heredity and, iv, 8
— surgical aspects of, xv, 53
— symptoms of, xi, 185
— treatment of, xi, 187; xv, 54
Hemophilic joint, xv, 149
Hemoptysis, tuberculosis and, ix, 230
Hemorrhage, abortion and, i, 43
— abruptio placentæ and, i, 52-56
— accidental, blood transfusion in, i, 103, 104
— — cardiac cases and, i, 33
— — placenta praævia distinguished from, i, 56
— — secondary shock and, i, 133
— — sepsis and, i, 91, 103
— acute, blood-picture following, xi, 60
— — course of, xi, 62
— — physical signs of, xi, 61
— — treatment of, xi, 62
— adrenalin for control of, respiratory diseases and, ix, 266
— alimentary tract, causes of, iii, 180
— — diagnosis of, iii, 184
— — general considerations of, iii, 180
— — pathology of, iii, 182
— — prognosis of, iii, 185
— — symptoms of, iii, 183
— — treatment of, iii, 185
— blood changes following, xx, 49
— brain injury and, v, 25
— brain, newborn, i, 139
— — facial paralysis and, i, 127
— — injuries and, i, 111, 137

Hemorrhage, Buhl's disease and, iii, 4
— bulbo-medullary, i, 118, 119, 120
— central nervous system, death at birth and, i, 118, 119, 120
— cerebral, breech delivery and, i, 114
— — infant deaths due to, i, 111
— — late manifestations of, xii, 142
— — mortality due to, ii, 3
— — newborn, i, 113, 137, 150
— — operative delivery and, i, 114
— — prematurity and, i, 114
— — spinal puncture in, i, 138
— — spontaneous delivery and, i, 114
— — stillbirths and, i, 112
— — whooping-cough causing, v, 81
— cerebrospinal, breech deliveries and, i, 117
— diseases associated with, xi, 177
— — idiopathic purpura hæmorrhagica, xi, 190
— — purpura, xi, 189
— — thrombopenic purpura, xi, 190
— dural, birth injuries and, i, 113
— early syphilis and, xvii, 138
— fetal tendencies to, i, 48
— foreign bodies in respiratory tract causing, ix, 191
— gastric, viii, 108
— genital, iii, 269
— gross, infantile paralysis causing, v, 103
— gross meningeal, v, 42
— hemophilia and, xi, 182
— hemorrhagic disease of newborn and, ii, 235
— hepatic, iii, 199
— history of patient and, i, 17
— icterus causing, ii, 224
— idiopathic tendency to, newborn, i, 138
— influenza causing, iii, 29
— intestinal, hemorrhagic disease and, ii, 235
— — mortality due to, ii, 4
— intracranial, iii, 230
— — breast feeding and, ii, 155
— — cyanosis and, xviii, 76
— — effects of, v, 43, 47
— — newborn and, i, 120; ii, 172
— — stillbirths and, i, 111
— — transfusion for, v, 44
Hemorrhage, intraspinal, iii, 242
— labor and, premature, induction of, i, 107
— lacerations and, prevention of, i, 97
— massive newborn, v, 23
— meningeal, mortality from, ii, 4
— nasal, iii, 80
— petechial, asphyxia neonatorum and, ii, 192
— — scurvy causing, vi, 188
— placental, Credé expulsion causing, i, 97
— — fetal death due to, i, 9
— placenta prævia and, i, 56-61
— postpartum, i, 11, 97, 130
— — chart, illus., i, 134
— prematurity and, ii, 166
— prenatal care and, i, 12, 15, 16, 49
— prevention of, newborn and, calcium treatment in, i, 139
— puerperal infections and, i, 91
— — maternal death-rate due to, i, 4
— renal, iii, 269
— retinal, v, 18
— retroplacental, i, 53, 55
— — death in utero and, i, 107
— scurvy causing, vii, 204; x, 221, 225
— sepsis neonatorum causing, iii, 13
— spinal cord, newborn, i, 117, 120, 122
— splenic, iii, 121
— subcortical, cerebral palsy following, v, 149
— subdural cerebral at birth, i, 117
— suprarenal, iii, 387
— traction on spinal cord causing, v, 35
— typhoid fever complicated by, viii, 190
— umbilical, iii, 401
— — mortality from, ii, 4
— urobilinuria following, xx, 11
— uterine, size of child affected by, ii, 14
— ventricular, newborn and, ii, 172
— whooping-cough causing, xiv, 124
Hemorrhagic arthritis, Still's disease differentiated from, vii, 105
Hemorrhagic disease of newborn, iii, 119

Hemorrhagic disease of newborn, blood changes in, xx, 51
— blood conditions underlying, ii, 232
— blood-count in, xi, 179
— bronchopneumonia and, ii, 236
— case history of, xi, 178
— clinical picture of, xi, 179
— diagnosis of, ii, 237; xi, 180
— etiology of, ii, 230; xi, 177
— factors to be considered, ii, 234
— frequency of, ii, 7, 228
— mortality due to, ii, 5
— pathology encountered in, ii, 235
— prematurity and, ii, 172
— prognosis of, ii, 238
— serum treatment of, ii, 239
— symptoms of, ii, 235
— treatment of, xi, 181
— Winckel's disease and, iii, 2
Hemorrhagic encephalitis, arsphenamin injections followed by, xvii, 272
Hemorrhagic nephritis, forms of, xix, 102, 106, 107
— general considerations of, xix, 101
Hemorrhagic pneumonia, iii, 81
Hemorrhagic polymyositis, vii, 234
Hemorrhagic purpura, xi, 189
— blood changes in, xx, 63
— idiopathic, blood-picture of, xi, 197
— — case history of, xi, 190
— — course of, xi, 198
— — diagnosis of, xi, 198
— — etiology of, xi, 194
— — physical signs of, xi, 197
— — symptoms of, xi, 196, 206
— — treatment of, xi, 199
— surgical aspects of, xv, 51
Hemorrhagic smallpox, xiv, 90
Hemorrhagic telangiectasia, hereditary, xvi, 296
Hemorrhoids, xv, 348
— newborn, iii, 196
— treatment of, viii, 294
Hemosiderin, hyperpigmentation due to, xvi, 284, 285
Hemothorax, treatment of, xv, 218
— Winckel's disease and, iii, 2
Henderson's shoulder splint, vi, 43
Henoch's purpura, xi, 189
— blood changes in, xx, 53
Henoch's purpura, diagnosis of, viii, 274
— first description of, xi, 5
— hematuria and, xix, 69
— intussusception differentiated from, viii, 260
— symptoms of, viii, 273; xvi, 68
Hepatic insufficiency, biliousness and, viii, 327
Hepatitis, infectious, etiology of, viii, 325
— syphilitic, pathological evidence of, xvii, 28
Herd instinct, hygiene and, iv, 86
— preventive pediatrics and, iv, 72
Hereditary ataxia, iv, 8
— orthopedic management of, vi, 250
Hereditary atrophic muscular dystrophy, simple, vii, 255
Hereditary bone deficiency, fragilitas ossium, vi, 190
Hereditary edema of the legs, xvi, 309
Hereditary hemolytic icterus, ii, 224
Hereditary hemorrhagic telangiectasia, xvi, 296
Hereditary muscular atrophy, Leyden-Möbius', vii, 255
Hereditary syphilis, bone necrosis and, newborn and, i, 72
— clinical cures in, prognosis of, xvii, 253
— criteria of cure in, xvii, 256
— definition of, xvii, 1
— diagnosis of clinical manifestations in, xvii, 242
— — laboratory tests in, xvii, 242
— drugs used in treatment of, xvii, 259
— involvement of nervous system in, frequency of, xvii, 174
— pregnancy and, i, 66-78
— prognosis of factors influency, xvii, 251
— prophylaxis of, iv, 146; xvii, 258
— spontaneous recovery in prognosis of, xvii, 254
— treatment of, xvii, 258
— — outline for, xvii, 268
— — results of, xvii, 281
— — special methods of, xvii, 266
Heredity, acute bronchitis and, ix, 102
— adenoids and, ix, 69

Heredity, alkaptonuria and, iv, 8
— angioneurotic edema and, xvi, 77
— asthma and, iv, 11; ix, 111
— body habitus and, iv, 12
— cancer and, iv, 11
— chronic tonsillitis and, ix, 57
— color-blindness and, iv 8
— "constitution" and, iv, 12
— defective mental development and, v, 186
— diabetes insipidus and, iv, 8
— eczema and, iv, 11
— enuresis and, xix, 50
— environment and, iv, 12
— epilepsy and, v, 139
— equality at birth and, iv, 11
— eugenics and, iv, 8, 9
— feeble-mindedness and, iv, 9
— fetal chondrodystrophy and, vii, 14
— food idiosyncrasies and, xii, 95
— Friedreich's ataxia and, iv, 8; v, 61
— funnel-chest and, vii, 50
— general considerations of, ii, 2
— general physical characteristics and, iv, 10
— growth and, ii, 44; xiii, 19
— hair color and, iv, 8
— harelip and cleft-palate and, iii, 131
— height and, iv, 10
— hemophilia and, iv, 8; xi, 186
— hemorrhage and, newborn and, i, 138, 139
— Huntington's chorea and, iv, 8
— hyperpigmentation and, xvi, 284
— immunity and susceptibility and, iii, 8; xii, 140, 149
— inanition and, x, 205
— infant death during first year and, i, 8
— instincts and, iv, 73
— malformations of gastro-intestinal tract and, iii, 130
— malnutrition and constitution, iv, 152
— mental ability and, iv, 9
— milk production and, xii, 166
— mongolism and, xiii, 153
— mortality rate and, iv, 12
— muscular atrophy and, iv, 8
— nervous system and, v, 60
— nevi and, xvi, 10
Heredity, obesity and, x, 149
— osteopsathyrosis and, iv, 8
— physical variations and, iv, 11
— pollen fevers and, ix, 118
— polydactylism and, iv, 8, 11
— preventive pediatrics and, iv, 8
— progressive muscular atrophy, v, 69
— pseudohypertropic dystrophy and, v, 61
— psoriasis and, xvi, 127
— rheumatic heart disease and, xviii, 11, 74
— sensitization and, viii, 317
— subnormal mentality and, iv, 9
— susceptibility to colds and, ix, 4
— syndactylism and, iv, 8
— tooth deformities and, iv, 89
— transmission of syphilis through, xvii, 63
— tuberculosis and, ix, 221; xiv, 339
Hermaphroditism, iii, 268; xix, 223
Hernandez, syphilis described by, xvii, 7
Hernia, amniotic, xv, 257
— cerebellar decompression causing, v, 120
— diaphragmatic, iii, 161
— — clinical features of, xv, 248
— — cyanosis caused by, ii, 205
— — physical signs of, xv, 251
— — treatment of, xv, 253
— — types of, xv, 247
— epigastric, treatment of, xv, 266
— femoral, diagnosis and treatment of, 265
— funicular, iii, 160
— hydrocele differentiated from, xix, 213
— inguinal, iii, 160
— — complications of, xv, 262
— — diagnosis of, xv, 261
— — mechanics of, xv, 259
— — treatment of, xv, 263
— — varieties of, xv, 261
— intestinal obstruction caused by, iii, 196
— medullary, 18
— newborn, iii, 156
— umbilical, iii, 156
— — treatment of, xv, 256, 258
— ventral, iii, 159; xv, 265

Hernia, ventral, growth and, xv, 2
Heroin, dermatitis caused by, xvi, 48, 52
Herpes, cerebrospinal meningitis causing, v, 78
— forms of, xvi, 84
— ganglion cells and, v, 216
— ganglion cell inflammation causing, v, 78
— meningococcic meningitis causing, v, 89
Herpes iris, xvi, 60
Herpes labialis, viii, 12
Herpes progenitalis, xvi, 85
Herpes simplex, diagnosis of, xvi, 87
— etiology of, xvi, 86
— herpes zoster differentiated from, xvi, 92
— impetigo contagiosa differentiated from, xvi, 207
— pathology of, xvi, 86
— prognosis of, xvi, 87
— symptoms of, xvi, 84
— treatment of, xvi, 87
Herpes zoster, iii, 331
— arsenic causing, xvi, 52
— derivation of the term, xvi, 87
— diagnosis of, xvi, 92
— etiology of, xvi, 91
— herpes simplex differentiated from, xvi, 87
— pathology of, xvi, 91
— prognosis of, xvi, 93
— symptoms of, xvi, 88
— treatment of, xvi, 92
Herpetic fever, xvi, 85
Herpetic stomatitis, diagnosis of, xvi, 342
— etiology of, viii, 24; xvi, 342
— prognosis of, xvi, 343
— symptoms of, viii, 25; xvi, 342
— treatment of, viii, 26; xvi, 342
Herter's infantilism, x, 241
Herxheimer reaction, arsphenamin injections followed by, xvii, 279
— avoidance of, treatment of congenitally syphilitic infants and, i, 83
Hess incubator, ii, 179
Heubner's pedonephritis, xix, 106
Hibbs' bone plasty, spinal tuberculous and, vi, 94
Hibbs' fusion operation, scoliosis and, vi, 269
Hilus tuberculosis, ix, 247
Hip-joint, acute infectious arthritis and, vi, 60
— acute traumatic arthritis of, vi, 120
— ankylosis of, vi, 17
— Bradford frame and, vi, 34
— compensatory lumbar lordosis of, vi, 17, 19
— congenital dislocation of, diagnosis of, vii, 59
— — etiology of, vii, 58
— — examination of, vii, 59
— — symptoms of, vii, 58
— — treatment of, vii, 60
— congenital malformations of, vii, 57
— deformities of, congenital dislocation of, vi, 288
— dislocations of, vi, 178
— inspection of, vi, 15
— measurements in examination of, vi, 18
— Nélaton's line and examination of, vi, 18
— orthopedic apparatus for, vi, 34
— orthopedic examination of, vi, 15
— palpation of, vi, 16
— passive motion in examination of, vi, 16
— poliomyelitis affecting, operative measures for, vi, 233
— poliomyelitis and, vi, 224
— sprain of, vi, 120
— Thomas splint for, vi, 37
— traumatic dislocation of, vii, 60
— Trendelenburg's sign, vi, 16
— tuberculosis of, diagnosis of, vi, 82
— — differential diagnosis of, vii, 127
— — pathology of, vi, 81
— — perinephritic abscess differentiated from, xix, 176
— — prognosis of, vi, 83; vii, 127
— — symptoms of, vi, 82; vii, 125
— — treatment of, vi, 83; vii, 127
— x-ray examination of, vi, 18
Hip-joint disease, differential diagnosis of, vii, 127

Hip-joint disease, prognosis of, vii, 127
— symptoms of, vii, 125
— treatment of, vii, 127
— tuberculosis of spine, differentiated from, vii, 123
Hippocrates, tuberculosis described by, ix, 216
Hippocratic nail, xvi, 267
Hirschsprung's disease, iii, 152
— anatomy of, viii, 240
— celiac disease differentiated from, viii, 213
— character of stools in, xx, 73
— characteristics of, viii, 239
— constipation and, xii, 126
— course of, viii, 244
— diagnosis of, viii, 242
— etiology of, viii, 240
— growth and, xv, 2, 322
— pathology of, viii, 240
— prognosis of, viii, 244; xv, 2, 322
— symptoms of, viii, 241
— treatment of, viii, 243; xv, 2, 322
History, pregnant patients, i, 17
History card, orthopedic, vi, 5, 7
Hives, course of, xvi, 74
— diagnosis of, xvi, 75
— etiology of, xvi, 74
— pathology of, xvi, 74
— prognosis of, xvi, 76
— symptoms of, xvi, 73
— treatment of, xvi, 76
Hodgkin's disease, blood changes in, xi, 124; xx, 55
— case history of, xi, 121
— characteristics of, xi, 120, 122
— diagnosis of, xi, 124
— leukemia and, xi, 130
— mediastinal tumors and, ix, 212
— original work in, xi, 3
— physical signs of, xi, 123
— prurigo and, xvi, 82
— symptoms of, xi, 123
— treatment of, xi, 125
Hollow-back, orthopedic management of, vi, 269
Holstein cows, milk from, xii, 13, 166
Homatropin, ophthalmoscopic examination and, v, 17
Home-pasteurized milk, advantages of, xii, 18
Homines pilosi, xvi, 252
Homogenous bone grafts, congenital fractures and, vi, 176
Hookworm, xvi, 171
— intestinal infestation with, viii, 303
Hooping cough, synonyms of, xiv, 117
Hormones, food, x, 21
— mammary gland secretion and, ii, 141
— milk secretion and, iv, 44
Hornification, vitamin A deficiency and, x, 22
Horseback riding, pregnancy and, i, 24, 168
— abortion and, i, 45
Horse serum, streptococcic infections of animals and, i, 101
Horseshoe kidney, development of, xix, 10
Hospital chart, newborn, ii, 134
Hospital maternity service, i, 152, 158
— abnormal cases and, i, 158, 162
— abortions and, i, 47
— deliveries and, i, 5, 90, 157, 158, 162
— midwifery and, i, 152, 154
— nurses and, i, 155
— placenta prævia cases and, i, 60
— puerperal infections in, i, 90
— rural, i, 159
— sepsis in, i, 5
Hot-cross-bun head, vii, 142
Housemaid's knee, orthopedic management of, vi, 217
Housework, pregnancy and, i, 168
Howell-Jolly bodies, significance of, xi, 13, 15
Human tuberculosis, distribution of, iv, 144
Humeroscapular reflex, ii, 113
Humerus, fracture of, iii, 298; vi, 156
— — birth and, xv, 69
— — malunited, vi, 170, 172
— — peripheral nerve injury and, vi, 251
— — shaft, vi, 158
— — supracondylar, vi, 156
— postpartum fractures of, xv, 84

Humerus, subluxation of, birth palsy caused by, i, 125
Humidity, importance of, ii, 178
Hundswut, synonyms of, xiv, 324
Hunger, air, asthma and, ix, 115
— desirability of, xii, 56
— indications of, xii, 92
— reaction of infant to, iv, 65
— sensation appearing early, ii, 116
— signs of, hypo-alimentation and, xii, 189
— stomach and effects of, viii, 91
— vomiting caused by, xii, 100, 114
Hunger contractions in newborn stomach, ii, 85
Hunger cry, breast milk and, i, 145
Hunter, work on syphilis by, xvii, 7
Huntington's chorea, heredity and, iv, 8
— marriage and, iv, 10
Hutchinson's teeth, vii, 149; viii, 69
— clinical description of, xvii, 215
— congenital syphilis and, i, 70
— pathology of, xvii, 40
Hutchinson's triad of syphilis, xvii, 11, 230
Hydatid cyst, lungs and, ix, 186
Hydatid disease, liver and, viii, 330
Hydroa puerorum, xvi, 97
Hydroa vacciniforme, diagnosis of, xvi, 97
— etiology of, xvi, 96
— pathology of, xvi, 96
— prognosis of, xvi, 97
— symptoms of, xvi, 94
— treatment of, xvi, 97
Hydroadenitis destruens suppurativa xvi, 217
Hydrocele, congenital syphilis and, iii, 49
— diagnosis of, xix, 213
— forms of, xix, 212
— general considerations of, iii, 262
— hernia differentiated from, xv, 261
— treatment of, xv, 267
— varieties of, xv, 266
Hydrocephalus, air injection and x-ray in diagnosis of, v, 115
— atelectasis caused by, iii, 88
— brain tumor indicated by, v, 117
— bulging of fontanels in, v, 43
Hydrocephalus, causes of, v, 113
— cerebrospinal fluid pressure in, v, 14
— cerebrospinal meningitis complicated by, xiv, 283
— cleft-palate and, vii, 54
— convulsions and, v, 137
— direction of enlargement in, v, 94
— drug treatment of, v, 115
—education impracticable for those inflicted with, v, 209
— fever resulting in, v, 79
— hypertonic saline solution and, v, 106
— internal, iii, 220; v, 113
— — case history of, v, 56
— — cerebral palsy due to, v, 150
— MacEwen's sign in, v, 10
— mechanics of, v, 111
— meningitis causing communicating type of, v, 94
— neurosyphilis clinically manifested by, xvii, 188
— operative treatment of spina bifida contra-indicated by, xv, 214
— pineal tumor and symptoms of, xiii, 74
— pneumonia causing, v, 150
— prognosis of, v, 48
— spina bifida and, v, 51
— spina bifida repair followed by, vii, 49
— tentorial tear with hemorrhage and, v, 46
— types of, vii, 53
— varieties of, iii, 219
— vomiting and, viii, 95
— Wassermann reaction in, v, 82
— whooping-cough causing, v, 150
Hydrochloric acid, free, ii, 87
— protein digestion and, x, 37
Hydro-encephalocele, definition of, xv, 152
Hydrogen-ion concentration, acidification of milk and, xii, 21
— blood of premature infants, ii, 166
— duodenal contents in infants and, xx, 91
— gastric contents in infancy and, xx, 89
— normal, mechanism for maintenance of, xx, 167

Hydrogen-ion concentration, stools in infancy and, xx, 71
Hydrogen-ion values, ii, 98
Hydrogen peroxid, rhinitis treated with, iii, 78
Hydromelia, iii, 223
Hydronephrosis, congenital, iii, 267
— forms of, xix, 194
— pathology of, xix, 193
— secondary, abnormalities causing, xix, 10, 11
— symptoms of, xix, 195
— treatment of, xix, 196
— urinary obstruction and, xv, 351
— Wilms' tumor differentiated from, xix, 186
Hydrophobia, characteristics of, xv, 11
— clinical features of, xv, 12
— pathology of, xv, 13
— synonyms of, xiv, 324
— treatment of, xv, 13
Hydrops articuli, congenital syphilis and, vii, 96
Hydrotherapy, acute laryngitis indicating, ix, 78
— bronchopneumonia and, ix, 135
— lobar pneumonia and, ix, 164
— respiratory diseases and, ix, 259
Hygiene, bowel regulation and, iv, 89
— child, education and, iv, 172
— — historical considerations of, iv, 171
— — infant welfare and, iv, 177
— — prenatal clinics and, iv, 176
— — preschool children and, iv, 179
— — preventive pediatrics and, iv, 169
— — Public Health nurses and, iv, 175
— clothing and, iv, 87
— constipation and, iv, 90
— dental, importance of, viii, 69
— — permanent teeth and, viii, 71
— — prenatal care and, viii, 70
— — preschool child and, xiii, 70
— exercise and, iv, 85
— foot deformities and, iv, 88
— games and, iv, 85
— general, respiratory diseases and, ix, 255
— importance of brothers and sisters, iv, 92
Hygiene, kindergartens and, iv, 92
— masturbation and, iv, 99
— menstruation and, iv, 98
— mental, preventive pediatrics and, iv, 65
— nursing, i, 140
— nursery schools and, iv, 92
— permanent teeth and, iv, 89
— play and, iv, 85
— pregnancy, instruction of public in, i, 156
— prenatal, i, 10
— preventive pediatrics and, iv, 83
— rest and, iv, 83
— school, preventive pediatrics and, iv, 180
— sepsis prevention and, i, 95
— sex education and, iv, 97
— sleep and, iv, 83
— teeth and their care, iv, 88
— thumb sucking, iv, 89
— tuberculosis and, i, 28
— vacations and, iv, 86
— venereal disease and, iv, 100
Hygromata, congenital cystic, surgical aspects of, xv, 63
— cystic, iii, 97
— — surgery of, xv, 197
Hymen, anatomy of, xix, 19
— embryology of, xix, 6
— imperforate, xix, 222
Hymenoptera, xvi, 161
Hyoscin, value in encephalitis, v, 101
Hyperalimentation, nursing and, xii, 189
Hyperemia, active, xvi, 57
— hemorrhage of alimentary tract from, iii, 181
— hypostatic, iii, 90
— passive, xvi, 56
Hyperexcitability, electrical, tetany showing, v, 131
Hyperglycemia, conditions causing, xx, 161
— diseases associated with, xiii, 14
Hyperidrosis, etiology of, xvi, 275
— pathology of, xvi, 275
— symptoms of, xvi, 274
— treatment of, xvi, 275, 350
Hyperkeratosis diffusa congenita, iii, 336

Hypernephroma, iii, 275
— malignant, xiii, 94
— — Wilms' tumor differentiated from, xix, 185
Hyperperistalsis, hypertrophic pyloric stenosis and, viii, 116
Hyperpigmentation, classification of, xvi, 284
Hyperpituitarism, growth influenced by, xiii, 22
Hyperplasia, adrenal, xiii, 94
Hyperplastic tonsillitis, ix, 57
Hyperpnea, acidosis causing, xx, 170
Hypertension, essential, epistaxis and, ix, 18
Hyperthyroidism, eczema and, xvi, 117
— experimental, xiii, 71
— hyperglycemia and, xiii, 14
— iodin and, xv, 202
— metabolism and, xiii, 12
— prognosis of, xiii, 49
— symptoms of, xiii, 47
— tests of thyroid function in, xiii, 48
— thymus in, xiii, 92
— treatment of, xiii, 49
Hypertonicity, definition of, v, 1
Hypertonic saline solution, hydrocephalus and, v, 106
— infantile paralysis and, v, 106
Hypertrichosis, etiology of, xvi, 252
— types of, xvi, 251
Hypertrophic osteo-arthropathy, pulmonary, vii, 80
Hypertrophic pyloric stenosis, congenital, clinical features of, xv, 285
— — diagnosis of, xv, 288
— — incidence of, xv, 283
— — operative results of, xv, 296
— — operative treatment of, xv, 292
— — treatment of, xv, 290
— diagnosis and differentiation of, viii, 119
— etiology of, viii, 114
— incidence of, viii, 114
— nomenclature and history of, viii, 113
— pathology and physiology of, viii, 115
— prognosis of, viii, 117, 124
— symptoms of, viii, 113, 115
Hypertrophic pyloric stenosis, treatment of, viii, 121
— — surgical, viii, 123
Hypertrophic rhinitis, etiology of, ix, 12
— symptoms of, ix, 12
— treatment of, ix, 13
Hypertrophic tonsillitis, ix, 57
Hypertrophied nails, xvi, 264
Hypertrophied tonsils, anatomy of, ix, 50
Hypertrophy, cardiac, diagnosis of, xviii, 199
— congenital, iii, 311
— congenital bone, orthopedic considations of, vi, 274
— digital, iii, 287
— gingival, viii, 14
— idiopathic congenital of heart, iii, 105
— mammary gland, cause of, ii, 142
Hypnosis, enuresis and, xix, 56
Hypnotism, stammering and, v, 197
Hypocalcemia, infantile tetany and, xx, 90
Hypodermoclysis, abruptio placentæ and, i, 56
— dehydration and, xiii, 43; xv, 22
— method of therapeutic use of, respiratory diseases and, ix, 273
— placenta prævia and, i, 60
— technic of, viii, 340
Hypogastric arteries, obliteration of, causes of, ii, 53
Hypoparathyroidism, symptoms of, xiii, 72
— treatment of, xiii, 73
Hypophyseal dwarfism, xiii, 152
Hypophyseal infantilism, characteristics of, xiii, 147
Hypophysis, icterus pigmentation of, ii, 223
Hypopituitarism, growth retardation in, xiii, 21
— infantilism and, xiii, 147
Hypospadias, iii, 266
— embryology of, xix, 7
— treatment of, xv, 357
— types of, xix, 213
— varieties of, xv, 355
Hypostatic hyperemia, iii, 90

Hypostatic pneumonia, etiology of, ix, 171
— newborn, iii, 84
— pathology of, ix, 171
— treatment of, ix, 172
Hypothyroidism, differential diagnosis of, xiii, 52
— growth retardation in, xiii, 21
— mild, definition of, xiii, 70
— types of, xiii, 52
Hypotrichiasis, iii, 350
Hysterectomy, abruptio placentæ and, i, 56
— pregnancy and, i, 42
— puerperal sepsis and, i, 104
Hysteria, v, 170
— enuresis and, xix, 48
— familial syphilis and, xvii, 106
— painful nipple caused by, ii, 152
— poliomyelitis differentiated from, xiv, 244
— skin eruptions and, xvi, 54
— tetanus differentiated from, xiv, 301
— tuberculosis of spine differentiated from, vi, 91
Hysterical paralysis, orthopedic considerations of, vi, 254
Hysterical torticollis, diagnosis of, vi, 293
Hysterotomy, tuberculous women and, i, 29

Ice compresses, counterirritant use of, respiratory diseases and, ix, 258
Ichthyosis, acanthosis nigricans differentiated from, xvi, 312
— diagnosis of, xvi, 17
— etiology of, xvi, 16
— fever caused by, xiii, 39
— keratosis follicularis differentiated from, xvi, 310
— symptoms of, xvi, 13
— treatment of, xvi, 17
— types of, xvi, 13
Ichthyosis congenita, iii, 336; xvi, 16
Ichthyosis congenita mitior, iii, 336
Ichthyosis congenita par exochen, iii, 336
Ichthyosis congenita tarda, iii, 337
Ichthyosis hystrix, xvi, 16
Ichthyosis sebacea, xvi, 16
Ichthyosis simplex, xvi, 13
Icterus, bile pigments and, ii, 72
— congenital, iii, 200
— familial, iii, 200
— familial hemolytic, case history of, xi, 116
— hereditary hemolytic, ii, 224
— nuclear, iii, 222
— prematurity and, ii, 172
— Winckel's disease and, iii, 2
Icterus gravis, blood changes in, xx, 52
Icterus index, xx, 39
Icterus neonatorum, blood changes in, xx, 51
— cause of, ii, 213
— differential diagnosis, ii, 225
— forms of, ii, 219
— inherent characteristics of, ii, 7
— jaundice and, ii, 218
— mortality of, ii, 4
— symptoms of, ii, 217
— theories as to nature of, ii, 215
— treatment of, ii, 226
Icterus neonatorum gravis, ii, 220
— diagnosis of, ii, 224
Icterus neonatorum prolongata, ii, 219
Icterus neonatorum simplex, ii, 219
— diagnosis of, ii, 224
Identification, methods of, ii, 126
Idiocy, definition of, v, 185
— general considerations of, iii, 251
— infant, instrumental birth and, i, 111
— macroglossia in, iii, 130
— Mongolian, Little's disease differentiated from, vi, 240
— prolonged labor and, i, 112
Idiopathic anemias, Banti's disease, xi, 99
— Gaucher's disease, xi, 113
— hemolytic jaundice, xi, 116
— Hodgkin's disease, xi, 120
— splenic anemia, xi, 101
— von Jaksch's anemia, xi, 98
Idiopathic congenital hypertrophy of heart, iii, 105
Idiopathic dilatation of colon, congenital, growth, prognosis and treatment of, xv, 2, 322

Idiopathic hemorrhages, newborn and, ii, 228
Idiopathic non-thrombopenic purpura, case history of, xi, 205
— course of, xi, 209
— diagnosis of, xi, 208
— etiology of, xi, 205
— physical signs of, xi, 207
— symptoms of, xi, 206
— treatment of, xi, 209
Idiopathic purpura, blood changes in, xx, 53
— surgical aspects of, xv, 51
Idiopathic purpura hæmorrhagica, blood-picture of, xi, 197
— case history of, xi, 190
— course of, xi, 198
— diagnosis of, xi, 198
— etiology of, xi, 194
— physical signs of, xi, 197
— symptoms of, xi, 196
— treatment of, xi, 199
Idiopathic visceral purpura, xi, 5
Idiosyncrasies, food, xii, 95, 96
Idiots, amaurotic familial, education impracticable for, v, 209
— — general considerations of, v, 219
Ileocecal intussusception, xv, 313
Ileocolitis, acute, course of lesions of, viii, 175
— — description of, viii, 173
— — diagnosis of, viii, 178
— — etiology of, viii, 173
— — intussusception differentiated from, viii, 260
— — lesions of, viii, 174
— — prognosis of, viii, 179
— — propylaxis of, viii, 182
— — symptoms of, viii, 176
— — treatment of, viii, 180
— ketosis caused by, xx, 170
— typhoid fever differentiated from, xiv, 200
Ileum, obstruction of, treatment of, xv, 279
— stenosis of, Meckel's diverticulum and, iii, 165
Ileus, acquired, pathology of, iii, 196
Ilium, transplant of crest of, tuberculosis of hip and, vi, 84
Imagination, development period of, x, 73
Imbecility, definition of, v, 185
Imitation, preventive pediatrics and, iv, 70
Immaturity, early infant death caused by, i, 6
— fetal death due to, i, 9
Immunity, acquired, xiv, 5
— active intra-uterine, iii, 9
— colostrum and, ii, 144
— communicable diseases and, iv, 128
— diphtheria in newborn and, iii, 23
— diphtheria toxin-antitoxin producing, xiv, 178
— diphtheria, transmission of, ii, 72
— euglobulin and, ii, 73
— growth mechanism forming, iii, 8
— heredity and, iii, 8
— infection and, general aspects of, xiv, 2
— measles and, xiv, 56
— measles in newborn and, iii, 27
— methods of development of, iii, 8
— mumps and, xiv, 150
— natural, xiv, 6
— — tuberculosis and, xiv, 336
— newborn blood and, ii, 72
— passive, infancy protected by, iv, 128
— passive intra-uterine, iii, 8
— smallpox, newborn and, iii, 21
— — vaccination and degree of, iv, 140
— transmission to children by syphilitic mother, xvii, 74
— tuberculous glands and, xiv, 340
Immunity and susceptibility, later infancy and childhood and, xii, 140
Immunization, pollen fevers and, ix, 120
— prophylactic, prevention of "colds" by, iv, 132
Impaction, fecal, intestinal obstruction caused by, viii, 239
Imperforate anus, iii, 167; viii, 287
— treatment of, xv, 341
Imperforate hymen, xix, 222
"Imperial" drink, toxemias of pregnancy and, i, 37

Imperial Granum, xii, 43
Impetigo, alopecia following, xvi, 256
— follicular, etiology of, xvi, 216
— — pathology of, xvi, 216
— — symptoms of, xvi, 216
— — treatment of, xvi, 217
— hydroa vacciniforme differentiated from, xvi, 97
— lupus vulgaris differentiated from, xvi, 228
Impetigo contagiosa, diagnosis of, xvi, 207
— eczema differentiated from, xvi, 118
— etiology of, xvi, 207
— nail changes due to, xvi, 268
— pathology of, xvi, 207
— pemphigus vulgaris differentiated from, xvi, 101
— prognosis of, xvi, 210
— smallpox differentiated from, xiv, 95
— symptoms of, xvi, 204
— treatment of, xvi, 208
— vaccination complicated by, xiv, 114
— varieties of, xvi, 205
Impetigo contagiosa bullosa, iii, 325
Impfpocken, synomyms of, xiv, 104
Inadequate feeding, results of, xii, 70
Inanition, actual cause of death in, x, 215
— acute, course of, x, 158
— — etiology of, x, 156
— — immediate effects of, x, 209
— — prognosis of, x, 158
— — symptoms of, x, 157; xiii, 24
— — treatment of, x, 158; xiii, 24
— acute fasting or, xiii, 24
— age and endurance of, x, 204
— anhydremia and, x, 159
— animal experimentation in, x, 199
— asphyxia in, x, 216
— bronchopneumonia and, x, 216
— chronic, xiii, 25
— definition of, x, 200
— effects of, x, 199
— — prophylaxis and, x, 217
— height not affected by, x, 212
— ketosis-acidosis associated with, xiii, 28
— malnutrition and, x, 155
— marasmus and, x, 164
Inanition, metabolism in, xiii, 25
— muscle affected by, x, 216
— pathological physiology of, xiii, 23
— period of endurance of, x, 207
— plant life restricted by, x, 200
— posture and, x, 217
— recovery from, x, 207
— ultimate results of, x, 199
— undernutrition in infancy, x, 161
— water, x, 215
Inanition fever, characterized by early appearance, ii, 7
— complemental feeding and, ii, 156
— congenital atresia of esophagus causing, iii, 137
— physiologic aspects of, ii, 50
— water content of blood and, ii, 76
— water deprivation and, x, 215
Inches and centimeters, equivalent table of, x, 290
Incidence of syphilis, among adults, xvii, 86
— among children, xvii, 90
— among men, xvii, 88
— among women, xvii, 88
— familial, xvii, 100
— in both sexes, xvii, 86
— in colored race, xvii, 89
Incipient rickets, vii, 176
Incisors, permanent, syphilitic stigmata of, xvii, 215
Incubator, body heat maintained by, ii, 178
— dehydration fever and, ii, 211
— Hess, ii, 179
— transitory fever and, ii, 211
— types of, ii, 179
— use during first few hours, ii, 130
Indican, ii, 90
— pyelitis cases and, i, 35
— urine and, ii, 106
— urine of pregnancy and, i, 21
Indicanuria, early appearance of, ii, 7
— significance in newborn, xx, 3, 8
— tissue destruction and weight loss shown by, ii, 38
Indigestion, acute intestinal, complications of, viii, 170
— — course of, viii, 168
— — diagnosis of, viii, 169

Indigestion, acute intestinal, etiology of, viii, 166
— — prevention of, viii, 170
— — symptoms of, viii, 168
— — treatment of, viii, 170
— character of stools in, xx, 72, 73
— chronic gastric, treatment of, viii, 107
— chronic intestinal, description of, viii, 204
— — infantilism and, x, 140
— — treatment of, viii, 205
— fat, xii, 78, 82, 84, 86
— — carbohydrates and, xii, 47
— fat causing, infant feeding and, i, 145
— food idiosyncrasies and, xii, 6
— gastric, birth injuries and, xii, 110
— — diet and régime and, xii, 111
— — food changes in, xii, 109
— — history of, xii, 109
— — meat in presence of milk causing, xii, 130, 134
— — prematurity and, xii, 110
— — prenatal causes of, xii, 109
— — vomiting and, xii, 111
— — weaning and, xii, 110
— intestinal, constipation in, xii, 125
— — diarrhea in, xii, 122
— — food changes in, xii, 118
— — nursing and, xii, 189
— — stools in, xii, 119, 121
— pregnancy and, i, 164
Individualism, development period of, x, 75
Indol, ii, 90
Induction of premature labor, i, 106-110
— gonorrhea prohibiting, i, 61
— methods of, i, 107
Inertia, labor and, i, 91
Infancy, additions to diet in, iv, 48
— alimentary anemia in, viii, 102
— anatomy during, x, 51
— anemia secondary to malnutrition in, xi, 64
— artificial feeding during, iv, 51
— average weight for height in, iv, 19
— birth weight in, iv, 17
— blood-pictures during, xi, 37, 39
Infancy, blood-pictures during, first through twelfth month, xi, 41
— — first to second year, xi, 41
— bowel regulation in, iv, 89
— brain tumors rare in, v, 117
— breast feeding in, iv, 41
— causes of postural defect in, iv, 36
— chronic blood loss in, blood-count in, xi, 62
— chronological schema for, iv, 200
— clothing in, iv, 87
— colic in, manifestations of, viii, 99
— — treatment of, viii, 99
— — types of, viii, 98
— communicable disease rare in first half year of, iv, 128
— complemental feeding in, iv, 49
— contra-indications for nursing during, iv, 48
— convulsions in, v, 130
— diet in later months of, iv, 55
— disorders of carbohydrate metabolism in, general considerations of, xx, 157
— early, digestive disturbances in. viii, 100
— eczema in, xvi, 113
— frequency of respiratory infection during, iv, 131
— gastric contents in, information derived from examination of, xx, 89
— gastro-enterospasm of, viii, 126
— gastro-intestinal infections in, iv, 146
— gestation and birth weight in, iv, 16
— growth statistics covering, iv, 16
— habit formation during, iv, 67, 73
— head and chest measurement in, iv, 30
— heat exhaustion in, viii, 102
— hydrogen-ion concentration of duodenal contents in, xx, 91
— hypertrophic pyloric stenosis of, viii, 113
— importance of urinalysis in, xx, 1
— infectious diseases of, acute rheumatic fever, xiv, 388
— — cerebrospinal meningitis, xiv, 265
— — chickenpox, xiv, 69

Infancy, infectious diseases of, diphtheria, xiv, 153
— — epidemic encephalitis, xiv, 254
— — erysipelas, xiv, 399
— — erythema infectiosum, xiv, 320
— — German measles, xiv, 62
— — influenza, xiv, 379
— — introduction to, xiv, 1
— — malaria, xiv, 209
— — measles, xiv, 34
— — mumps, xiv, 141
— — poliomyelitis, xiv, 224
— — rabies, xiv, 324
— — scarlet fever, xiv, 10
— — septic sore-throat, xiv, 308
— — smallpox, xiv, 80
— — tetanus, xiv, 296
— — tuberculosis, xiv, 332
— — typhoid fever, xiv, 188, 195
— — vaccinia, xiv, 104
— — whooping-cough, xiv, 117
— influence of economic conditions on, iv, 115
— influence of feeding in, iv, 117
— influence of race in, iv, 116
— instincts and emotions in, iv, 69
— malnutrition in, iv, 150
— mental development in, iv, 56
— mental measurements in, iv, 79
— monthly weight gain during, iv, 24
— morbidity and mortality in, iv, 105
— mortality by age, iv, 110
— mortality rate, iv, 108, 109
— mortality rate by causes of death, iv, 111
— normal blood chemistry values in, xx, 129
— normal weight gain during, iv, 24
— nursing and alimentary disturbances in, viii, 97
— nursing intervals during, iv, 45
— overfeeding in, iv, 47
— paratyphoid fever in, symptoms of, viii, 196
— passive immunity to communicable diseases in, iv, 128
— period of, length of, iv, 25; x, 50
— prevention of diphtheria in, iv, 132
— psychology of, xii, 149
Infancy, pylorospasm of, viii, 126
— reaction of hematopoietic system in, xi, 21
— record forms for, iv, 192
— rest and sleep during, iv, 83
— rickets in, iv, 122
— rumination in, symptoms of, viii, 131
— scurvy in, iv, 124
— specific disease prevention in, iv, 122
— stools in, viii, 142
— — abnormal, xx, 72
— — acidity of, xx, 71
— — character of, xx, 71
— surgery of, abdomen, xv, 272
— — abdominal contusions, xv, 296
— — abdominal tuberculosis, xv, 302
— — acidosis, xv, 24
— — acute cervical adenitis, xv, 189
— — acute intussusception, xv, 313
— — acute retropharngeal abscess, xv, 178
— — acute suppurative sialo-adenitis, xv, 188
— — adhesion of clitoris and prepuce, xv, 355
— — adrenal tumors, xv, 369
— — alkalosis, xv, 26
— — anal fissure, xv, 345
— — appendicitis, xv, 305
— — back, xv, 206
— — blood diseases, xv, 50
— — bone diseases, xv, 118
— — bone tuberculosis, xv, 140
— — bone tumors, xv, 125
— — branchial cysts, xv, 183
— — branchial fistulæ, xv, 184
— — Brodie's abscess, xv, 139
— — burns and scalds, xv, 15
— — cellulitis of neck, xv, 191
— — cervical auricles, xv, 188
— — cervical ribs, xv, 188
— — chest, xv, 218
— — choice of anesthetic, xv, 29
— — circumcision, xv, 353
— — clinical examination in, xv, 3
— — congenital hypertrophic pyloric stenosis, xv, 283
— — congenital kidney anomalies, xv, 364

Infancy, surgery of, congenital sacrococcygeal sinuses and fistulæ, xv, 217
—— congenital syphilis, xv, 46
—— congenital tongue-tie, xv, 174
—— cystic hygroma, xv, 197
—— cysts of face, xv, 173
—— dehydration, xv, 22
—— developmental bone disease, xv, 119
—— developmental errors of gastro-intestinal tract, xv, 272
—— diaphragmatic hernia, xv, 247
—— empyema, xv, 225, 231
—— enteric cysts, xv, 339
—— epididymis and testis, xv, 371
—— epigastric hernia, xv, 266
—— epispadias, xv, 359
—— ether administration, xv, 30
—— eventration of diaphagm, xv, 253
—— exstrophy of bladder, xv, 357
—— face and mouth, xv, 166
—— femoral hernia, xv, 265
—— fistula in ano, xv, 348
—— foreign bodies in chest, xv, 240
—— fractures and epiphyseal separations, xv, 66
—— general considerations of, xv, 1
—— genito-urinary, xv, 349
—— goiter, xv, 200
—— harelip and cleft-palate, xv, 166
—— head, xv, 151
—— hemangiomata, xv, 57
—— hemolytic jaundice, xv, 54
—— hemophilia, xv, 53
—— hemophilic or bleeder's joint, xv, 149
—— hemorrhoids, xv, 348
—— hernia, xv, 256
—— hydrocele, xv, 266
—— hydrophobia, xv, 11
—— hyperthyroidism, xv, 202
—— hypospadias, xv, 355
—— imperfectly descended testis, xv, 267
—— inguinal hernia, xv, 259, 263
—— injuries of chest, xv, 218
—— intestinal obstruction, xv, 320
—— jaundice in sepsis of newly born, xv, 311
—— jaw, xv, 181
Infancy, surgery of, joint diseases, xv, 144
—— liver and bile-ducts, xv, 330
—— lung abscess, xv, 236
—— lymphangiomata, xv, 62
—— macroglossia, xv, 175
—— macrostomia, xv, 173
—— malformations of anus and rectum, xv, 341
—— mastitis, xv, 221
—— mediastinitis, xv, 246
—— megacolon, xv, 322
—— neck, xv, 183
—— omental and mesenteric cysts, xv, 338
—— Osgood-Schlatter's disease, xv, 141
—— osteomyelitis, xv, 129, 137
—— perianal and ischiorectal abscess, xv, 347
—— peritonitis, xv, 299
—— peritonsillar abscess, xv, 180
—— phimosis, xv, 352
—— postoperative care, xv, 31
—— precautions during operation, xv, 30
—— preoperative care, xv, 28
—— prolapse of rectum, xv, 345
—— pyelitis, xv, 359
—— pyloric stenosis, xv, 283
—— quinsy, xv, 180
—— rabies, xv, 11
—— ranula, xv, 176
—— rectal polyp, xv, 344
—— rectum and anus, xv, 341
—— renal cysts, xv, 364
—— retroperitoneal abscess, xv, 311
—— rickets, xv, 41
—— sacrococcygeal tumors, xv, 215
—— sarcoma of intestine, xv, 339
—— scurvy, xv, 34
—— shock, xv, 23
—— spina bifida, xv, 206, 215
—— splenic anemia and Gaucher's disease, xv, 335
—— suppurative pericarditis, xv, 244
—— synovitis and arthritis, xv, 148
—— tetanus, xv, 9
—— thymus, xv, 203
—— thyroglossal cysts and fistulæ, xv, 185

Infancy, surgery of, thyroid, xv, 200
— — torsion of spermatic cord, xv, 271
— — transfusion, xv, 32
— — tuberculosis of cervical glands, xv, 192
— — tuberculosis of kidney, xv, 365
— — tuberculosis of ribs and sternum, xv, 225
— — tumor incidence, xv, 56
— — tumors of breast, xv, 225
— — tumors of kidney, xv, 366
— — tumors of mediastinum, xv, 247
— — tumors of ovary, xv, 337
— — tumors of testis, xv, 372
— — ulcers of frenum, xv, 175
— — umbilical affections, xv, 281
— — umbilical hernia, xv, 256
— — urinary lithiasis, xv, 362
— — ventral hernia, xv, 265
— — Vincent's angina, xv, 180
— — wounds of soft parts, xv, 8
— syphilitic facies in, description of, xvii, 228
— teeth in, iv, 32, 88
— temper tantrums in, iv, 76
— temperature peculiarities in, xii, 140
— thermic fever in, viii, 102
— tuberculosis in, iv, 143, 144
— underfeeding in, iv, 45
— vaccination in, iv, 139
— vomiting in, viii, 92
— — causes inherent in food, viii, 93
— — central origin of, viii, 95
— — eruption of teeth and, viii, 94
— — frozen milk and, viii, 95
— — intestinal influenza and, viii, 95
— — mechanical vomiting, viii, 92
— — simple regurgitation, viii, 92
— — toxic, viii, 95
— — treatment of, viii, 96
— weaning, iv, 50
— weight and height by age, iv, 18
— welfare clinics and, iv, 192
Infant, artificially fed, constipation in, viii, 223
— breast-fed, constipation in, viii, 221
— death of, age rates of, i, 7, 8
Infant, death of, breast feeding and, i, 140
— — causes of, i, 7, 149
— — congenital causes of, i, 14
— — early, causes of, i, 6, 7
— — enlarged thymus and, i, 138
— — factory day nurseries and, i, 156
— — falx and tentorium rupture causing, i, 117
— — hemmorhages causing, central nervous system, i, 118, 119, 120
— — prenatal care and, clinical reports of, i, 10-13
— — seasonal, i, 4
— — sepsis causing, i, 98
— — spinal injuries causing, i, 121
— — syphilis causing, i, 7, 64, 65, 77, 84
— deformities of, i, 9, 67
— diarrheal diseases of, milk infection and, xx, 122
— feeding of, artificial, danger of, i, 157
— — bottle, i, 140, 141, 145
— — breast, i, 139-148, 173, 174
— — cod-liver oil in, i, 146
— — complementary, i, 145, 146
— — formula, sepsis and, i, 98
— foods for, x, 194
— glycosuria in, conditions causing, xx, 8
— health stations for, i, 156
— intestinal parasites in, pathogenicity of, xx, 76
— multiple abscesses of, xvi, 219
— newborn, abnormalities, i, 137, 138, 140
— — care of, i, 8, 136-139, 171-174
— — clothes and supplies for, i, 169, 171
— — crying of, i, 137, 145
— — eyes of, care of, i, 62, 137, 169
— — hemorrhages of, central nervous system, i, 118, 119, 120
— normal daily liquid intake for, xiii, 42
— nursing, carbohydrate requirement of, x, 17
— — cleft-palate and harelip and, viii, 9

Infant, nursing, difficulties encountered while, viii, 97
—— fat ingestion by, x, 30
——fat requirement of, x, 15
—— protein requirement of, x, 12
—— water requirement of, x, 19
— peritonitis in, clinical features of, xv, 299
—— etiology of, xv, 299
—— treatment of, xv, 301
— postnatal examination of, i, 160
— premature, anemia in, xx, 50
—— breast milk supply for, i, 157
— prenatal care and, i, 7
— syphilis and, i, 79
— pyelitis in, symptoms of, xix, 146
— syphilitic infection of, i, 63-66, 76
—— osteochondritis and, i, 70-73
—— treatment of, i, 81-83
—— Wassermann reaction and, i, 78
— transmission of syphilis to, xvii, 73
— type of, nutrition and, xvii, 4, 72
Infant feeding, additions to bottle feeding, xii, 129-135
— art of, xii, 143
—— clothing, xii, 144
—— education of parents, xii, 144
—— exercise and rest, xii, 146
—— sleep, xii, 147
—— training of infant, xii, 146
—— ventilation, xii, 145
— breast feeding, xii, 155, 170
—— management of, xii, 170
—— physiology, xii, 155
— caloric requirements, iv, 53
— contra-indications for nursing, iv, 48
— convulsions and, xii, 141
— definition of, xii, 4
— eating between meals, xii, 138
— education of mother in, iv, 43
— essentials of technic of, iv, 43
— essential points in, xii, 64
— fluid requirements, iv, 54
— food changes in gastric indigestion, xii, 109
— food changes in intestinal indigestion, xii, 118
— food requirements in normal children, xii, 57
Infant feeding, food requirements in premature infant, xii, 96, 102
— formula changes in normal infant, xii, 76
— formulas, xii, 69, 72
— growth and development and, xii, 7
— intervals in, xii, 137
— introductory remarks, xii, 1
— later infancy and childhood, xii, 136
— mental attitude of mother and, iv, 43
— milk—its source and preparation, xii, 9
— overfeeding, iv, 47
— patented and proprietary foods, iv, 51
— peculiarities in expression of disease, xii, 140
— physiological action of food constituents, xii, 44
— physiology of digestion, xii, 54
— preparations from milk, xii, 23
— psychology of infancy and, xii, 149
— quantity of food given, iv, 52
— reflexes and, xii, 140
— regularity in, xii, 137
— regularity of nursing important, iv, 44
— schedules for, xii, 137
— selective eaters, xii, 139
— standards for successful nursing, xii, 184
— substitutes for milk, xii, 34
— tolerance, xii, 7
— underfeeding analyzed, iv, 45
Infant morbidity, iv, 120
Infant mortality, age of mother and, iv, 116
— chief factors affecting, iv, 12
— decline in rate of, iv, 108
— diet and, iv, 117
— factors influencing rate of, iv, 114
— general discussion of, iv, 107
— housing relationships affecting, iv, 115
— ignorance and poverty affecting, iv, 114
— illegitimacy and, iv, 116
— maternal syphilis and, iv, 107
— measles and, iv, 136
— nativity of mother and, iv, 116

Infant mortality, race and, iv, 116
— rate in England and Wales, iv, 108
— respiratory infections and, iv, 112
— rural and urban rates for, iv, 113
— seasonal incidence of, iv, 112
— specific causes of, iv, 111
Infant weight chart, iv, 192
Infant welfare, child hygiene and, iv, 177
Infant welfare clinics, iv, 192
Infantile beriberi, x, 265
Infantile cerebral palsy, iii, 223
Infantile nephropathy, incidence of, xix, 129
Infantile paralysis, v, 102; vii, 240
— acute stage of, v, 104
— — treatment of, v, 105
— convalescent stage, v, 106
— — treatment of, v, 107, 110
— epidemic encephalitis and, v, 98
— infective nature of, v, 103
— orthopedic treatment of, v, 107
— symptoms of, v, 104
— synonyms of, xiv, 224
Infantile peritonitis, viii, 261
Infantile progressive muscular atrophy (Werdnig-Hoffmann type), vii, 252
Infantile scurvy, vii, 203
— etiology of, xvi, 71
— symptoms of, xvi, 71
— treatment of, xvi, 71
Infantile spinal meningitis, synonyms of, xiv, 224
Infantile syphilis, xvii, 1
Infantile tetany, xiii, 37
— blood changes in, xx, 175
— oral administration of HCl in, xx, 90
Infantilism, Brissaud type of, xiii, 147
— cardiac, x, 142
— definition of, x, 139
— diagnosis of, xiii, 146
— etiology of, x, 139
— fatty stools and, viii, 206
— Fröhlich's syndrome and, x, 142
— Herter's, x, 142
— hypophyseal, xiii, 147
— intestinal, x, 140
— metabolism of, xiii, 145
— prognosis of, xiii, 147
Infantilism, renal, xx, 153
— signs and symptoms of, xiii, 145
— treatment of, xiii, 147
— types of, x, 139
Infarcts, pulmonary, heart disease and, xviii, 127
— uric acid, ii, 103
— — hematuria caused by, xix, 69
— urinary, ii, 101
Infections, acute, acute fasting with vomiting in, xiii, 24
— — anemia due to, xx, 50
— — digestive symptoms and, xv, 1
— — hemoglobinuria and, xix, 68
— acute intestinal, frozen milk and symptoms of, xii, 19
— albuminuria resulting from, xx, 6
— alimentary hemorrhage and, iii, 181
— amniogenic, iii, 11
— blood-sugar and, xx, 161
— bone, iii, 308
— — acute, vi, 128; xv, 129
— — low-grade, vi, 136
— — susceptibility of children to, vi, 3
— chronic bacterial, nutritional needs and, xii, 6
— chronic malnutrition and, iv, 162
— craniovertebral, convulsions caused by, v, 129
— degenerative nephritis associated with, xx, 152
— diarrhea and, xii, 124
— familial cerebral palsy following, v, 147
— gastro-intestinal, malnutrition and, iv, 153
— — prevention of, iv, 146
— genito-urinary, iii, 270
— germ plasm and, iii, 10
— gonococcal, female genital organs and, xix, 225
— herpes zoster caused by, xvi, 92
— immunity and, general aspects of, xiv, 2
— inherited immunity protecting infant from, xii, 140
— joint, low-grade, vi, 68, 98
— ketosis-acidosis associated with, xiii, 29
— — treatment of, xiii, 30

Infections, ketosis caused by, xx, 170
— labor, i, 86-105
— lung, parasitic, ix, 185
— mammary gland, treatment of, xv, 224
— metabolism and, xiii, 5
— milk transmission of, xii, 13
— mongolism and respiratory, v, 191
— nephrosis and, xix, 88
— nephrosis associated with, xix, 79
— nervous system, v, 76
— newborn, acute, iii, 18
— puerperal, i, 86-105
— — abortion and, i, 6, 43, 47
— — bacteriology of, i, 87
— — blood transfusion, dosage, i, 103, 104
— — Census reports of, i, 2
— — charts, illus., i, 100, 102, 114
— — chemical treatment of, i, 104
— — eclampsia and, i, 92
— — endometritis and, i, 93
— — frequency of, i, 90
— — gonococcus causing, i, 61, 94
— — hygienic prevention of, i, 95, 96
— — labor followed by, i, 150
— — leukocyte count in, i, 101
— — maternal deaths due to, i, 4, 5, 11, 86
— — metritis and, i, 93
— — midwixes' responsibility in, i, 153
— — miscarriage and, i, 47
— — mortality rates in, i, 90
— — operative treatment of, i, 91, 104
— — pathology of, i, 88
— — placental, i, 91, 94
— — predisposing causes of, i, 91-95
— — prenatal care and, i, 5, 12
— — protein therapy and, i, 103
— — serums in, i, 99-103
— — specific treatment of, i, 99
— — staphylococcus aureus causing, i, 87
— — streptococcus causing, i, 87
— — symptomatology of, i, 93
— — thrombophlebitis and, i, 94
— — thrombosis and, i, 89
— — treatment of, i, 95-104
— pyogenic urinary tract, ascending infection causing, xix, 144
Infections, pyogenic urinary tract, bacteriology of, xix, 140
— — chronic form of, xix, 149
— — complications of, xix, 161
— — course of, xix, 161
— — definition of, xix, 138
— — diagnosis of, xix, 163
— — etiology of, xix, 139
— — hematogenous infection causing, xix, 143
— — history of, xix, 138
— — incidence of, xix, 139
— — localization of infection in, xix, 139
— — mode of infection in, xix, 143
— — pathology of, xix, 141
— — perinephritis and perinephritic abscess and, xix, 174
— — prognosis of, xix, 169
— — relapses in, xix, 161
— — symptoms of, xix, 146
— — treatment of, xix, 169, 173
— rheumatic, diseases included as, xviii, 52
— — prognosis of heart disease and recurrent attacks of, xviii, 210
— scar contractures following, vi, 201
— scurvy and, vii, 206
— secondary of nervous system, v, 80
— sepsis neonatorum, iii, 12
— source in newborn, iii, 10
— susceptibility of premature infant to, xii, 105
— syphilitic bone, characteristics of, vii, 135
— — diagnosis of, vii, 145
— — differential diagnosis of, vii, 149
— — early congenital lesions of, vii, 136
— — joint involvement in, vii, 148
— — late lesions of, vii, 146
— — treatment of, vii, 151
— syphilitic joint, diagnosis of, vii, 145
— — differential diagnosis of, vii, 149
— — nature of, vii, 135
— — symptoms of, vii, 148
— — treatment of, vii, 151
— tetany and, v, 135
— tuberculous bone, bone marrow changes in, vii, 114

Infections, tuberculous bone, diagnosis of, vii, 115
—— differential diagnosis of, vii, 116
—— general considerations of, vii, 108
—— incidence of human and bovine, vii, 109
—— occurrence of, vii, 112
—— pathology of, vii, 113
—— portal of, vii, 111
—— predisposing causes of, vii, 110
—— prognosis of, vii, 117
—— regional frequency of, vii, 113
—— special areas affected by, vii, 118
—— symptoms of, vii, 114
—— treatment of, vii, 117
—— types of organism causing, vii, 108
— tuberculous joint, cartilage changes in, vii, 114
—— diagnosis of, vii, 115
—— differential diagnosis of, vii, 116
—— general considerations of, vii, 108
—— incidence of human and bovine, vii, 109
—— occurrence of, vii, 112
—— pathology of, vii, 113
—— portal of, vii, 111
—— predisposing causes of, vii, 110
—— prognosis of, vii, 117
—— regional frequency of, vii, 113
—— special areas affected by, vii, 118
—— symptoms of, vii, 114
—— synovial membrane changes in, vii, 114
—— treatment of, vii, 117
—— types of organism causing, vii, 108
— umbilical, convulsions following, v, 129
— umbilicus as portal of, iii, 11
— upper respiratory, malnutrition and, iv, 153
—— prevention of, iv, 131
— vaccination complicated by, xiv, 113
— Winckel's disease and, iii, 1
Infectious adenitis, acute epidemic, synonyms of, xiv, 314
Infectious arthritis, acute, ankle manifestations encountered in, vi, 58
Infectious arthritis, acute, clinical course of, vi, 51
—— diagnosis of, vi, 52
—— elbow and, vi, 67
—— etiology of, vi, 50
—— foot management in, vi, 58
—— hand and, vi, 67
—— hip-joint and, vi, 60
—— joint tuberculosis differentiated from, vi, 71
—— knee and, vi, 59
—— laboratory and x-ray observations in, vi, 52
—— pathology of, vi, 50
—— physiotherapy and, vi, 57
—— prognosis of, vi, 54
—— psoas abscess and, vi, 60
—— shoulder-joint and, vi, 66
—— surgery and, vi, 53, 55
—— symptoms of, vi, 51
—— treatment of, vi, 54
—— wrist and, vi, 67
— acute osteomyelitis differentiated from, xv, 135
— chronic, clinical course of, vi, 103
—— diagnosis of, vi, 104
—— etiology of, vi, 102
—— pathology of, vi, 103
—— prognosis of, vi, 105
—— symptoms of, vi, 103
—— treatment of, vi, 105
—— types of, vi, 103
—— x-ray and, vi, 104
Infectious cold, synonyms of, xiv, 379
Infectious diarrhea, cerebral palsies caused by, v, 142
Infectious diseases, acute, blood pictures in, xi, 47-52
— acute rheumatic fever, xiv, 388
— anemia secondary to, xi, 69
—— course of, xi, 76
—— physical signs of, xi, 75
—— symptoms of, xi, 75
—— treatment of, xi, 77
— cerebrospinal meningitis, xiv, 265
— chickenpox, xiv, 69
— chronic, blood pictures in, xi, 53
— diphtheria, xiv, 153
— epidemic encephalitis, xiv, 254
— erysipelas, xiv, 399
— erythema infectiosum, xiv, 320

Infectious diseases, German measles, xiv, 62
— immunity of newborn to, iii, 7
— influenza, xiv, 379
— introduction to, xiv, 1
— malaria, xiv, 209
— measles, xiv, 34
— milk as carrier of, xx, 122
— mumps, xiv, 141
— placarding of, xiv, 8
— poliomyelitis, xiv, 224
— rabies, xiv, 324
— responsibility of practicing physician in, xiv, 1, 8
— scarlet fever, xiv, 10
— septic sore-throat, xiv, 308
— smallpox, xiv, 80
— susceptibility of newborn to, iii, 7
— tetanus, xiv, 296
— tuberculosis, xiv, 332
— typhoid fever, xiv, 188
— vaccinia, xiv, 104
— whooping-cough, xiv, 117
Infectious hepatitis, etiology of, viii, 325
Infectious mononucleosis, blood changes in, xx, 55
— blood-count in, xi, 47
— lymphatic leukemia differentiated from, xi, 141
— synonyms of, xiv, 314
Infectious osteomyelitis, acute, diagnosis of, vi, 131
— — etiology of, vi, 128
— — local manifestations of, vi, 129
— — pathology of, vi, 128
— — prognosis of, vi, 133
— — symptoms of, vi, 129
— — treatment of, vi, 135
— — x-ray and, vi, 130
Infectious purpura, viii, 273
Infectious spondylitis, acute, diagnosis of, vi, 64
— — prognosis of, vi, 64
— — psoas abscess and, vi, 62
— — symptoms of, vi, 62
— — treatment, vi, 66
— — tuberculosis of spine differentiated from, vi, 91
— — x-ray findings in, vi, 64
— chronic, symptoms of, vi, 104
Inferiority complex, preventive pediatrics and, iv, 70
Inflammatory diarrhea, acute, course of lesions of, viii, 175
— — description of, viii, 173
— — diagnosis of, viii, 178
— — etiology of, viii, 173
— — lesions of, viii, 174
— — prognosis of, viii, 179
— — prophylaxis of, viii, 182
— — symptoms of, viii, 176
— — treatment of, viii, 180
Inflammatory rheumatism, acute, chronic tonsilitis and, ix, 60
— — osteomyelitis differentiated from, xv, 135
— complications of, vii, 95
— diagnosis of, vii, 95
— etiology of, vii, 90
— pathology of, vii, 92
— prognosis of, vii, 98
— symptoms of, vii, 92
— synonyms of, xiv, 388
— treatment of, vii, 97
Influence of economic conditions in infancy, iv, 115
Influence of feeding in infancy, iv, 117
Influence of race in infancy, iv, 116
Influenza, acrodynia and, xiii, 134
— acute bronchitis and, ix, 101
— blood-count in, xi, 51
— breast feeding prevented by, ii, 150
— bronchopneumonia secondary to, ix, 122, 130
— cerebrospinal meningitis differentiated from, xiv, 281
— character of cough of, ix, 101
— chronic bronchitis following, ix, 107
— chronic rhinitis following, ix, 9
— complications of, xiv, 382
— definition of, xiv, 379
— diagnosis of, xiv, 383
— epidemiology of, xiv, 379
— etiology of, xiv, 380
— fetal death and, i, 48
— hematuria and, xix, 69
— history of, xiv, 379
— history of patient and, i, 17
— infant mortality and, iv, 111

Influenza, infection of fetus by bacillus of, iii, 10
— intestinal, vomiting in, viii, 95
— leukopenia in, xx, 46
— measles differentiated from, xiv, 48
— nasal accessory sinus disease and, ix, 26
— newborn and, iii, 29
— pathology of, xiv, 380
— prognosis of, xiv, 383
— prophylaxis of, xiv, 384
— Public Health regulations for, xiv, 386
— rheumatic infections and, xviii, 79
— smallpox differentiated from, xiv, 94
— symptoms of, xiv, 381
— synonyms of, xiv, 379
— treatment of, xiv, 384
— tuberculin test negatived by, ix, 231
Influenzal meningitis, cerebrospinal fluid in, xx, 110
Infraction, metatarsal, vi, 107
Infraspinatus, paralysis of, birth, i, 125
Inguinal hernia, iii, 160
— complications of, xv, 262
— diagnosis of, xv, 261
— mechanics of, xv, 259
— treatment of, xv, 263
— varieties of, xv, 261
Inhalations, method of therapeutic use of, respiratory diseases and, ix, 269
Inheritance, transmission of syphilis by, xvii, 63—*See also* Heredity.
Inherited syphilis, deafness and, xvii, 166
— early lesions of, general considerations of, xvii, 112
— late manifestations of, xvii, 141
Initial diarrhea of newborn, ii, 93
Initial weight loss, artificial food and, ii, 149
— complemental feeding and, ii, 155
— prematurity and, ii, 160
Injections, air, brain tumors and, v, 119
— intramuscular, method of therapeutic use of, ix, 274
Injections, intraperitoneal, method of therapeutic use of, ix, 275
— — technic of, viii, 341
— intravenous, method of therapeutic use of, ix, 276
Injuries, alimentary tract, iii, 186
— birth, anterior horn cells affected by, v, 213
— — bones involved in, iii, 290
— — brain, iii, 224
— — cerebral palsy due to, v, 149
— — cerebrospinal fluid and, xx, 117
— — cephalic, i, 8, 112
— — clavicular, i, 121, 123, 127
— — ear and, iii, 369
— — early infant death to, i, 7, 8
— — eye involvement in, iii, 363
— — extremities and, i, 121
— — fractures and epiphyseal separations, xv, 69
— — gastric indigestion and, xii, 110
— — infant mortality and, iv, 111
— — intrapartum, i, 111-129
— — kidney, iii, 269
— — late manifestations of cerebral hemorrhage caused by, xii, 142
— — nerves and, i, 124
— — obstetrical management and, i, 8
— — paralysis from, vii, 247
— — scalp and, xv, 152
— — spinal, i, 117
— bone, fractures resulting from, vii, 154
— — peculiarities of, vii, 153
— — rickets predisposing to, vii, 153
— brain, iii, 224
— chest, subcutaneous emphysema, xv, 220
— — surgery of, xv, 218
— dermatitis caused by, xvi, 34
— fetal death due to, i, 9
— hepatic, newborn, iii, 199
— peripheral nerve, postparalytic atrophy from, vii, 256
— permanent teeth and, viii, 68
— postpartum, fractures, xv, 81
— spinal cord, iii, 225
— umbilical, iii, 402
Inosculating atresia, esophageal, iii, 70

Insanity, breast feeding prevented by, ii, 150
— heredity and, v, 61
— nursing and, iv, 48
— puerperal, i, 40
Inspection, abdominal, viii, 267
— chest examination by, ix, 88
— first day, ii, 135
— lobar pneumonia and, ix, 147
Inspiratory laryngeal stridor, iii, 72
Instinct, herd, hygiene and, iv, 86
— preventive pediatrics and, iv, 69
— psychology of, iv, 69
— sex, hygiene, and, iv, 86
Instincts, emotions, and, iv, 69
Institutional care, cerebral palsies and, v, 147
— defective children and, v, 208
Institutions, maternity, prenatal care and, i, 155, 156
Insufficiency, aortic, diagnosis of, xviii 195
— — pathological physiology of, xviii, 46
— — physical signs of, xviii, 120
— — x-ray signs of, xviii, 158
— gastric, viii, 94
— hepatic, biliousness and, viii, 327
— mitral, diagnosis of, xviii, 196
— — pathological physiology of, xviii, 44
— — physical signs of, xviii, 114
— — x-ray signs of, xviii, 158
— tricuspid, diagnosis of, xviii, 198
— — pathological physiology of, xviii, 45
— — physical signs of, xviii, 123
Insufflation, oxygen, asphyxia neonatorum and, ii, 199
Insufflation pneumonia, diagnosis of, ix, 179
— etiology of, ix, 176
— — endogenous, ix, 176
— — exogenous, ix, 177
— pathology of, ix, 178
— prophylaxis of, ix, 180
— symptoms of, ix, 178
— treatment of, ix, 180
Insulin, carbohydrate metabolism and, x, 36
— diabetes mellitus and, xiii, 105
Insulin, marasmus and, x, 169
Insulin injections, nausea of pregnancy and, i, 26
Insurance, maternity, i, 156
Intake of food in calories during school age, iv, 40
Intelligence, delinquency and, v, 155
— tests for, v, 154
Interauricular septal defects, xviii, 131
Intercostal drainage, empyema and, xv, 232
Intercourse, pregnancy and, sepsis caused by, i, 95
— — abortion and, i, 45
— — retrodisplacement and, i, 20
Intermittent albuminuria, xx, 7
Internal hydrocephalus, case history of, v, 56
— cause of, iii, 220
— cerebral palsy due to, v, 150
— cerebrospinal meningitis and, xiv, 284
— pathology of, iii, 220
— symptoms of, iii, 221
— treatment of, iii, 222
— types of, iii, 220
— x-ray of, v, 57
Internal secretion, glands of, adrenal, xiii, 92
— — bone disturbances and, vi, 192
— — convulsions and disorders of v, 138
— — gonads, xiii, 95
— — growth influenced by, iv, 14; xiii, 21
— — interrelation of, xiii, 106
— — mental disorders and, v, 171
— — milk secretion inaugurated by, iv, 44
— — pancreas, xiii, 99
— — parathyroid, xiii, 71
— — pineal, xiii, 74
— — pituitary, xiii, 76
— — thymus, xiii, 87
— — thyroid, xiii, 44
— — ultraviolet rays influencing, x, 26
— nervous disorders and, v, 171
Internal strabismus, indications of, v, 149
Interscapular reflex, ii, 113

Interstitial cardiac edema, syphilis causing, iii, 58
Interstitial encephalitis, congenital, iii, 245
Interstitial keratitis, diagnosis of, hereditary syphilis and, xvii, 245
— late inherited syphilis and, xvii, 144
— latent syphilis causing, xvii, 225
— pathology of, xvii, 35
— treatment of, xvii, 281
Interstitial nephritis, chronic, blood chemistry in, xx, 153
— — clinical features of, xx, 152
— congenital syphilis causing, iii, 59
Interstitial pneumonia, chronic, ix, 168
Intertrigo, erythematous, iii, 320; xvi, 34
— — eczema differentiated from, xvi, 117
— prevention of, ii, 127
Intervals, breast feeding, ii, 147; xii, 167
— feeding, xii, 65, 80, 103
— — later infancy and childhood, xii, 137
— prematurity and, ii, 182
Interventricular septal defects, xviii, 131, 140
Intestinal indigestion, acute, character of stools in, xx, 73
— — complications of, viii, 170
— — course of, viii, 168
— — diagnosis of, viii, 169
— — etiology of, viii, 166
— — prevention of, viii, 170
— — symptoms of, viii, 168
— — treatment of, viii, 170
— chronic, character of stools in, xx, 73
— — description of, viii, 204
— — infantilism and, x, 140
— — treatment of, viii, 205
— constipation in, xii, 125
— diarrhea in, xii, 122
— food changes in, xii, 118
— nursing and, xii, 189
— stools in, xii, 119
— — interpretation of, xii, 121
Intestinal infantilism, x, 140
Intestinal infection, acute, frozen milk and symptoms of, xii, 19
Intestinal influenza, vomiting in, viii, 95
Intestinal intoxication, acute, indigestion and, xii, 125
— character of stools in, xx, 73
Intestinal obstruction, clinical features of, xv, 320
— diagnosis of, xv, 321
— etiology of, xv, 320
— pathology of, xv, 320
— treatment of, xv, 321
— umbilical hernia caused by, iii, 158
Intestinal parasites, general considerations of, viii, 295
— newborn and, iii, 35
— pathogenicity of, xx, 76
— varieties of, viii, 296, 299, 303, 305, 309; xx, 76
Intestinal toxemia, convulsions and, xii, 142
— erythema scarlatiniforme and, xvi, 59
Intestinal tuberculosis, character of stools in, xx, 74
Intestinal wall, increased permeability in newborn, ii, 209
Intestines, abnormalities of, viii, 140
— absorption of food in, ii, 89
— anatomy of, viii, 139
— bacteria in, ii, 118; viii, 144
— carbohydrate digestion in, viii, 142
— care of, pregnancy and, i, 21, 25
— congenital diverticula of, xv, 280
— congenital obstruction of, viii, 233
— congenital volvulus of, xv, 280
— convulsions and, i, 37
— cysts from wall of, xv, 339
— development of, x, 66, 74
— developmental errors of, xv, 275
— digestion in, viii, 141; xii, 55
— diseases of, acute dysentery, viii, 173
— — acute ileocolitis, viii, 173
— — acute inflammatory diarrhea, viii, 173
— — acute intestinal indigestion, viii, 166
— — acute surgical, viii, 249
— — amebic dysentery, viii, 305
— — appendicitis, viii, 249

Intestines, diseases of, celiac disease, viii, 206
— — chronic intestinal indigestion, viii, 204
— — chronic ulcerative colitis, viii, 198
— — congenital dilatation and hypertrophy of colon (Hirschsprung's disease), viii, 239
— — constipation, viii, 221, 226
— — diarrhea, viii, 149
— — dyspepsia in artificially fed infants, viii, 161
— — dyspepsia in breast-fed infants, viii, 158
— — dyspepsia in premature infants causing diarrhea, viii, 153
— — Hirschsprung's disease, viii, 239
— — infantilism with fatty stools, viii, 206
— — intussusception, viii, 255
— — malformation and obstruction, viii, 233
— — Meckel's diverticulum and, viii, 245
— — parasitic, viii, 295
— — paratyphoid fever, viii, 195
— — peptic duodenal ulcer, viii, 145
— — peritonitis, viii, 261, 276
— — protozoa causing, viii, 296, 299, 303
— — starch causing digestive injury, viii, 164
— — tuberculosis, viii, 276, 279
— — typhoid fever, viii, 184
— — visceroptosis, viii, 270
— — worms, viii, 295, 299, 304, 309
— duodenum, physiology of, viii, 140
— emptying time of, viii, 139
— extrinsic obstruction of, viii, 236
— fat digestion in, viii, 141
— heart conditions and, i, 32
— hemorrhage of, mortality due to, ii, 4
— length and position of, viii, 139
— malformation of, congenital microcolon, viii, 245
— — diagnosis of, viii, 236
— — etiology of, viii, 233
— — Hirschsprung's disease and, viii, 239
Intestines, malformation of, symptoms of, viii, 234
— newborn abnormalities of position of, iii, 155
— — acquired obstruction of, iii, 196
— — anatomy of, iii, 127
— — atresia of, iii, 145
— — congenital syphilis and, iii, 59
— — dimensions of, iii, 127
— — hemorrhage from, iii, 183
— — length of, iii, 127
— — perforation of, iii, 186
— — stenosis of, iii, 145
— obstruction of, diagnosis of, viii, 236
— — fecal impaction causing, viii, 239
— — intestinal stone causing, viii, 239
— — symptoms of, viii, 234
— peculiarities of, viii, 140
— physiology of, ii, 89; viii, 139
— protein digestion in, viii, 141
— pyelitis and, i, 34, 35
— sarcoma of, xv, 339
— starch digestion in, viii, 142
— stenosis of, symptoms of, viii, 235
— stools in infancy, viii, 142
— sugar digestion in, viii, 142
— tuberculosis of, xv, 305
— — relative frequency of, ix, 231
Intoxication, acute intestinal, indigestion and, xii, 125
— anhydremic, x, 159
— auto-, death from inanition and, x, 216
— intestinal, character of stools in, xx, 73
— parenal, prematurity and, ii, 171
Intracartilaginous ossification, vii, 3
Intracephalic lesions, early infant death and, i, 8
Intracerebral hemorrhage, results of, v, 47
Intracranial hemorrhage, asphyxia neonatorum and, ii, 195
— breast feeding and, ii, 155
— causes of, iii, 231
— cyanosis and, xviii, 76
— definition of, iii, 230
— diagnosis of, iii, 236
— differential diagnosis of, iii, 238
— effects of, v, 43

Intracranial hemorrhage, newborn and, ii, 155, 172
— pathology of, iii, 232
— prognosis of, iii, 240
— prophylactic treatment of, iii, 240
— symptomatic treatment of, iii, 241
— symptomatology of, iii, 234
— tentorial tear and, v, 46
— treatment of, iii, 241; v, 44
Intracranial injuries, v, 42
— prognosis of, v, 48
Intracranial pressure, birth, blood injections in, i, 115
— brain tumors causing increase of, v, 118
— convulsions and, v, 137
— drainage by lumbar puncture in, i, 113
— facial paralysis and, i, 127
— head injuries and, i, 113, 115
— hemorrhage and, i, 117, 120
— Macewen's sign and, v, 10
— pressure on internal jugular veins causing rise of, v, 122
— retinal findings in, v, 18
Intracutaneous tuberculin test, technic of, ix, 288
— typhoid fever negativing, 231
Intramembranous ossification, vii, 2
Intramuscular injections, neo-arsphenamin and, iii, 56
— method of therapeutic use of, respiratory diseases and, ix, 274
Intranatal syphilis, fetal death due to, i, 63
Intrapartum birth injuries, i, 111-129
— death caused by, i, 8
— extremites and, i, 121
— head and, i, 112
— nerves and, i, 124
— spinal cord and, i, 117
— vertebra and, i, 117
Intraperitoneal injection, method of therapeutic use of, respiratory diseases and, ix, 275
— technic of, viii, 341
Intraspinal hemorrhage, iii, 242, 244
Intraspinal therapy, syphilis and, xvii, 266
Intraspinal tumors, cerebrospinal fluid and, xx, 116
Intrathecal therapy, v, 82
Intra-uterine asphyxia, ii, 190
— symptoms of, ii, 193
Intra-uterine death, i, 48-50, 107, 108
Intra-uterine fractures, xv, 69
Intra-uterine pneumonia, iii, 83
Intra-uterine pressure, cleft-palate and, vii, 54
Intravenous injections, neo-arsphenamin and, iii, 55
— method of therapeutic use of, respiratory diseases and, ix, 276
Intravenous serum injection, meningococcic meningitis and, v, 90
Intubation, diphtheria of larynx and, xiv, 172
Intussusception, acute, clinical features of, xv, 314
— — differential diagnosis of, xv, 315
— — etiology of, xv, 313
— — onset of, xv, 3
— — prognosis of, xv, 4
— — sarcoma of intestine and, xv, 339
— — treatment of, xv, 316
— — varieties of, xv, 313
— anatomy and pathology of, viii, 256
— character of stools in, xx, 74
— chronic, xv, 317
— course of, viii, 258
— description of, viii, 255
— diagnosis of, viii, 260
— etiology of, viii, 256
— newborn, iii, 196
— symptoms of, viii, 257
— treatment of, viii, 260
Invagination, intestinal, viii, 255
Invalidism, poor obstetrics and, i, 150
Invertase, carbohydrate digestion by, x, 33
Inverted nipple, ii, 152
Invertin, ii, 84, 89
Involucrum, definition of, vi, 129; vii, 67
Iodids, acute bronchitis caused by, ix, 102
— acute laryngitis and, ix, 79
— asthma and, ix, 115
— atrophic rhinitis and, ix, 14
— chronic pneumonia and, ix, 170
— chronic rhinitis and, ix, 12
— congenital syphilis and, iii, 54

Iodids, dermatitis caused by, xvi, 48, 50
— enlarged non-tuberculous bronchial glands and, ix, 210
— joint tuberculosis and, vi, 72
— syphilis of bones and joints and, vi, 102; vii, 151
— treatment of syphilis with, xvii, 262
Iodin, asepsis of labor and, i, 96, 109
— dermatitis caused by, xvi, 42
— exophthalmic goiter and, xiii, 49
— hyperthyroidism and, xv, 202
— simple goiter and, iv, 125; xiii, 46
— thyroid gland and percentage of, iv, 125
Iodinization of water supplies, iv, 125
Iodoferma, xvi, 50
Iodoform, dermatitis caused by, xvi, 42
Iodoform tamponage, i, 56
— abortion and, i, 29, 48
— placenta prævia and, i, 59
Ipecac, amebiosis and, ix, 186
— spasmodic laryngitis and, ix, 81
Iridocyclitis, congenital syphilis and, iii, 49
— syphilitic, pathology of, xvii, 36
Iris, anomalies of, iii, 361
— syphilis causing changes in, iii, 49
Iritis, puberty and, congenital syphilis and, i, 76
— syphilitic, incidence of, xvii, 138, 149
— — latent, xvii, 225
— — treatment of, xvii, 281
Iron, amount in fetus, ii, 47
— amount in muscles at birth, ii, 111
— atrophic rhinitis and, ix, 14
— chronic rhinitis and, ix, 12
— icterus and placenta and, ii, 214
— milk containing, ii, 146
— prematurity and amount in blood, ii, 166, 186
— tonic use of, respiratory diseases and, ix, 267
Iron perchlorid, alimentary hemorrhage and, iii, 186
Iron salts, digestion and metabolism of, x, 41
Irradiation, general, vii, 230
Irregular respiration, significance of, ix, 88
Irrigations, colonic, bicarbonate of soda, nausea and, i, 25
— — pyelitis and, i, 34, 35, 36
— — respiratory diseases and method of theapeutic use of, ix, 267
— — toxemias and, i, 37
— throat, method of therapeutic use of, ix, 285
— uterus, septicemia caused by, i, 90
Irritation, pregnancy and, i, 101
— — toxemias of, i, 37
Ischemic muscular atrophy, vii, 239
Ischemic myositis, vii, 239
— diagnosis of, vi, 212
— etiology of, vi, 211
— pathology of, vi, 212
— prognosis of, vi, 213
— symptoms of, vi, 212
— treatment of, vi, 213
Ischemic paralysis, management of, vii, 159
Ischiorectal abscess, xv, 347
Iso-agglutinins, ii, 73
Isohemolysins, ii, 73
Isolation, ii, 137
— prevention of contagion and, iv, 129
Itch, dhobie, xvi, 194
— grain, xvi, 159
Ixodoidea, xvi, 158

Jackets, orthopedic, plaster-of-Paris, vi, 40
Jacksonian convulsions, v, 136
Jacquet, erythema of, iii, 319
Jarisch-Herxheimer reaction, arsphenamin injections causing, xvii, 279
Jaundice, acholuric, blood changes in, xx, 61
— arsphenamin injections followed by, xvii, 272, 275
— benign, round-worms causing, viii, 328
— catarrhal, blood-count in, xi, 55
— — character of stools in, xx, 74
— — incidence of, viii, 326
— — treatment of, viii, 327
— congenital acholuric, xi, 5
— congenital and familial icterus and, iii, 200

Jaundice, congenital atresia of bile-ducts and, xv, 330
— congenital obliteration of bile-ducts causing, iii, 202
— familial, blood changes in, xx, 61
— Hayem-Widal's, xi, 5
— hemolytic, blood changes in, xx, 61
— — case history of, xi, 116
— — character of stools in, xx, 74
— — characteristics of, xi, 116
— — diagnosis of, xi, 119
— — first description of, xi, 5
— — surgical aspects of, xv, 54
— — symptoms of, xi, 118
— — treatment of, xi, 120
— — urobilin in, xx, 11
— hemorrhage and, iii, 184
— icterus neonatorum and, ii, 218
— Minkowski-Chauffard's, xi, 5
— obstructive, bile pigments in urine in, xx, 12
— — icterus index in, xx, 40
— sepsis of newborn and, xv, 311
— surgical aspects of, xv, 330
— weight loss and, ii, 37
Jaw, congenital absence of, iii, 131
— congenital ankylosis of, iii, 131
— congenital anomalies of, iii, 130
— diseases of, iii, 188; xv, 181
— necrosis of, viii, 16
— sarcoma of, viii, 17
— special differences between adult and infant, vii, 6
— tumor of, viii, 16
Jaw-jerk reflex, ii, 113
Jealousy, malnutrition and, iv, 164
— preventive pediatrics and, iv, 77
Jejunum, obstruction of, treatment of, xv, 279
Jenner, vaccinia and, xiv, 104
Jerking respiration, significance of, ix, 88
Jersey cows, milk from, xii, 13
Jigger, xvi, 168
Joint-mouse, vii, 80
Joints, acute affections of, vi, 50
— — infectious arthritis, vi, 50
— — infectious spondylitis, vi, 62
— acute rheumatic fever and, xiv, 391
— affections of, orthopedic, vi, 47
Joints, anaphylactic, Still's disease differentiated from, vii, 105
— ankylosis of, treatment of, vii, 61
— blood dyscrasias and, vi, 125
— chickenpox and, xiv, 75
— diseases of, acute infective synovitis and arthritis, xv, 145
— — heliotherapy and actinotherapy in, vii, 217, 228
— — hemophilic or bleeder's joint, xv, 149
— — traumatic synovitis, xv, 144
— hemophilic, xv, 149
— inflammations of, general considerations of, vii, 83
— low-grade affections of, vi, 68, 98
— — ankle tuberculosis, vi, 76
— — arthritis deformans, vi, 106
— — chronic infectious arthritis, vi, 102
— — coxa plana, vi, 108
— — coxa valga, vi, 114
— — coxa vara, vi, 111
— — elbow tuberculosis, vi, 95
— — foot tuberculosis, vi, 76
— — hip tuberculosis, vi, 81
— — knee tuberculosis, vi, 78
— — Köhler's disease, vi, 107
— — Legg's disease, vi, 108
— — osteochondritis, vi, 107, 114
— — Perthes' disease, vi, 108
— — Pott's disease, vi, 85
— — shoulder tuberculosis, vi, 95
— — spinal tuberculosis, vi, 85
— — Still's disease, vi, 106
— — syphilis, vi, 98
— — tuberculosis, vi, 68, 85
— — upper extremity tuberculosis, vi, 95
— — wrist tuberculosis, vi, 96
— malignant tumors of, vi, 126
— neoplasms affecting, vi, 125
— newborn, anatomy of, iii, 278
— rheumatic fever affecting, xviii, 18, 53
— — *See also* Polyarthritis
— scarlet fever involving, xiv, 21
— septic, thrombophlebitis causing, i, 94
— syphilis of, concomitant infections in, vi, 101

Joints, syphilis of, diagnosis of, vi, 101; vii, 145
— — differential diagnosis of, vii, 149
— — late manifestations of, xvii, 149
— — nature of, vii, 135
— — pathology of, vi, 98; xvii, 35
— — prognosis of, vi, 102
— — Still's disease differentiated from, vii, 105
— — symptoms of, vi, 99; vii, 148
— — treatment of, vi, 102; vii, 151
— — types of, vi, 99
— — Wassermann test in, vi, 101
— — x-ray examination of, vi, 100
— traumatic affections of, vi, 118
— — acute arthritis, vi, 118
— — blood dyscrasias, vi, 125
— — malignant tumors, vi, 126
— — neoplasms, vi, 125
— — subacute arthritis, vi, 123
— — tumors, vi, 125
— tuberculosis of, xiv, 356
— — cartilage changes in, vii, 114
— — diagnosis of, vii, 115
— — differential diagnosis of, vii, 116
— — general considerations of, vii, 108
— — incidence of human and bovine, vii, 109
— — mode of infection in, vii, 111
— — occurrence of, vii, 112
— — pathology of, vii, 113
— — predisposing causes of, vii, 110
— — prognosis of, vii, 117
— — regional frequency of, vii, 113
— — special areas affected by, vii, 118
— — Still's disease differentiated from, vii, 105
— — symptoms of, vii, 114
— — synovial membrane changes in, vii, 114
— — treatment of, vii, 117
— — types of organism causing, vii, 108
— tumors affecting, vi, 125
— x-ray examination of, vi, 9
Jones' splint, vi, 44
Jugular veins, internal, intracranial pressure and, v, 122
Juvenile arthritis deformans, course of, vii, 104
Juvenile arthritis deformans, diagnosis of, vii, 104
— etiology of, vii, 99
— nomenclature of, vii, 98
— pathology of, vii, 102
— prognosis of, vii, 105, 107
— signs and symptoms of, vii, 103
— treatment of, vii, 106
Juvenile muscular atrophy, vii, 256
Juvenile osteomalacia, characteristics of, vii, 44, 45
Juvenile paralysis agitans, v, 71
Juvenile paresis, cerebrospinal fluid in, xx, 104

Kahn reaction, blood examination by, xvii, 45
— relative value of Wassermann test and, xx, 69
Karrel diet, toxemias of pregnancy and, i, 37
Kassowitz's law of syphilis transmission, xvii, 11, 75
Keloid, etiology of, xvi, 315
— prognosis of, xvi, 316
— symptoms of, xvi, 315
— treatment of, xvi, 316
Keratitis, interstitial, diagnosis of hereditary syphilis and, xvii, 245
— — late inherited syphilis and, xvii, 144
— — latent syphilis causing, xvii, 225
— — pathology of, xvii, 35
— — symptomatology of, xvii, 145
— — treatment of, xvii, 281
— parenchymatous, late inherited syphilis and, xvii, 144
— puberty and, congenital syphilis and, i, 76
Keratomalacia, incidence of, xiii, 129
— symptoms of, xiii, 129
— treatment of, xiii, 130
Keratosis, arsenic causing, xvi, 52
Keratosis diffusa fetalis, iii, 336
Keratosis follicularis, diagnosis of, xvi, 310
— etiology of, xvi, 310
— prognosis of, xvi, 311
— symptoms of, xvi, 309

Keratosis follicularis, treatment of, xvi, 311
Keratosis follicularis contagiosa, incidence of, xvi, 311
— keratosis follicularis differentiated from, xvi, 310
Keratosis palmaris et plantaris, etiology of, xvi, 18
— symptoms of, xvi, 17
— treatment of, xvi, 18
Keratosis pilaris, keratosis follicularis differentiated from, xvi, 310
Kerion, symptoms of, xvi, 176
Kerley-Cabot's respiratory diagrams, ix, 92, 95, 96
Kernig's sign, cerebrospinal meningitis and, xiv, 275, 281
— infantile paralysis and, v, 104
— lobar pneumonia and, ix, 186
— meningitis and, v, 85
— neurosyphilis and, xvii, 186
Kerr treatment, cranial indentations and, i, 113
Keto-acids, carbohydrate deficiency and, x, 16
Ketone bodies, fat digestion and, xiii, 16
Ketosis, acidosis caused by, xx, 170
— fatty acids determining grade of, xiii, 27
— incidence of, xv, 25
— treatment of, xx, 171
Ketosis-acidosis, conditions associated with, xiii, 28
— pathological physiology of, xiii, 27
— symptoms of, xiii, 28
— treatment of, xiii, 29
Keuchusten, synonyms of, xiv, 117
Kidney, absence of, incidence of, xix, 9
— acidosis originating in, xiii, 31
— anatomy of, iii, 258; xix, 16
— anomalies and malformations of, iii, 264
— birth injuries of, iii, 269
— Buhl's disease causing fatty degeneration of, iii, 4
— concentration test for function of, xix, 39
— congenital anomalies of, xv, 364
— congenital cystic, iii, 267
Kidney, congenital cystic, development of, xix, 3
— — symptoms of, xix, 12
— — Wilms' tumor differentiated from, xix, 186
— congenital floating, iii, 265
— congenital syphilis and, iii, 59
— cysts of, xv, 364
— development of, x, 67, 77
— dilution-concentration test for function of, xix, 39
— diseases of, acidosis and, xiii, 25, 31
— — amyloidosis, xix, 101
— — bilateral hematogenous renal disease, xix, 75
— — chronic diffuse nephropathy, xix, 125
— — death in utero and, i, 107
— — eclampsia and, i, 39
— — hemorrhagic nephritis, xix, 101
— — history and, patient's, i, 17
— — hydronephrosis, xix, 193
— — infantile nephropathy, xix, 129
— — malignant tumors in region of kidney, xix, 183
— — methods of diagnosis of, xix, 34
— — nephrosis, xix, 78
— — pregnancy and, i, 18
— — — care of, i, 32, 166
— — puerperal sepsis and, i, 91
— — pyelitis and, i, 34, 35
— — renal stasis, xix, 128
— — rupture, xix, 193
— — stones, xix, 180
— — syphilis, xix, 192
— — tuberculosis, xix, 188
— — urine analysis and, i, 18, 21, 160, 162, 166
— embryology of, xix, 1
— excretion of acids by, xx, 168
— experimental inflammation of, xix, 24
— functional tests of, xix, 36; xx, 19
— horseshoe, development of, xix, 10
— hypernephroma of, iii, 275
— malformations of, embryological considerations of, xix, 8
— malignant tumors in region of, diagnosis of, xix, 185
— — incidence of, xix, 183

Kidney, malignant tumors in region of, symptoms of, xix, 184
— — treatment of, xix, 187
— malposition of, xix, 10
— nerve control of, xix, 22
— newborn seldom showing disease of, ii, 7
— pathological physiology of, xix, 23
— pelvis of, capacity of, xix, 16
— — pyogenic infection of, xix, 138
— physiology of, xix, 21
— polycystic, clinical signs of, xx, 155
— prenatal function of, ii, 100
— rheumatic carditis and, xviii, 89
— rheumatic infection of, pathology of, xviii, 40
— rupture of, xix, 193
— scarlet fever and, xiv, 20, 30
— size of, xix, 16
— sodium chlorid test for function of, xix, 41
— solitary cysts of, incidence of, xix, 13
— stones of, diagnosis of, xix, 182
— — formation of, xix, 180
— — symptoms of, xix, 181
— — treatment of, xix, 182
— syphilis of, xix, 192
— — early manifestations of, xvii, 140
— — pathological evidence of, xvii, 29
— tuberculosis of, iii, 273; xiv, 355
— — diagnosis of, xix, 190
— — heliotherapy contra-indicated in, ix, 260
— — incidence of, xix, 69, 188
— — pathology of, xv, 365
— — relative frequency of, ix, 231
— — symptoms of, xix, 190
— — treatment of, xv, 366; xix, 191
— tumors of, clinical features of, xv, 367
— — diagnosis of, xv, 368
— — incidence of, xv, 366
— — treatment of, xv, 369
— typhoid pathology of, viii, 191, 192
— urea test for function of, xix, 42
— water test for function of, xix, 37
— weight of, xix, 16
— weight at birth, iii, 258
— Wilms' tumor of, diagnosis of, xix, 185
Kidney, Wilms' tumor of, incidence of, xix, 183
— — symptoms of, xix, 184
— — treatment of, xix, 187
Kindergartens, hygiene and, iv, 92
Kinepox, synonyms of, xiv, 104
Klebs-Löffler, diphtheria and, xiv, 154
Kleinschmidt-Czerny butter-flour mixtures, xii, 39
Klim, composition of, xii, 32
Klumpke paralysis, iii, 227
Knee, acute infectious arthritis and, vi, 59
— acute traumatic arthritis of, vi, 119
— braces for, vi, 33
— Buck's extension and, vi, 29
— Campbell-Mitchner splint for flexion-deformity of, vi, 60
— congenitial laxity of, vi, 13
— crepitation in, vi, 13
— deformities of, germ recurvatum, vi, 287
— — malformation and rotary displacements of, vi, 288
— examination of, vi, 12
— friction fremitus in, vi, 13
— "housemaid's," orthopedic management of, vi, 217
— hyperextension of, vi, 287
— inspection of, vi, 12
— malformation of, vi, 288
— orthopedic examination of, vi, 12
— orthopedic management of, plaster-of-Paris and, vi, 29
— poliomyelitis involving, vi, 223
— — operative measures for, vi, 232
— rotary displacements of, vi, 288
— scar contractures of, vi, 208
— sprain of, vi, 119
— subacute traumatic arthritis of, vi, 123
— Thomas' splint for, vi, 30
— tuberculosis of, prognosis of, vi, 79
— — symptoms of, vi, 78
— — treatment of, vi, 80
— x-ray of, vi, 14
Knee-chest position, misplacements prevented by, i, 19, 161
— pyelitis and, i, 35
Knee-jerk reflex, ii, 113
— significance of, v, 11

Knee-joint, congenital dislocation of, vii, 57
— ossification of bones forming, maturity determined by, x, 61
— tuberculosis of, diagnosis of, vii, 129
— — pathology of, vii, 128
— — prognosis of, vii, 130
— — symptoms of, vii, 129
— — treatment of, vii, 130
Knock-knee, vii, 281
— pathology of, vi, 185
— rickets causing, vi, 182
— treatment of, vi, 185
— tuberculosis causing, vi, 78
Köhler's disease, definition of, vi, 107
— etiology of, vii, 75, 77
— joint tuberculosis differentiated from, vi, 77
— symptoms and treatment of, vi, 145
— treatment of, vii, 77
Koilonychia, xvi, 269
Koplik spots, measles and, xiv, 38, 40
Krause method, bougie introduction by, i, 110
Krause skin grafts, scar contractures and, vi, 205
Kromayer lamp, nevi and, xvi, 11
Kümmell's disease, osteochondritis and, vi, 115
— tuberculosis of spine differentiated from, vi, 91
Kumyss, preparation of, xii, 37
Kyphosis, acute infectious spondylitis and, vi, 62
— Bradford frame and, vi, 38
— congenital, iii, 282
— definition of, vi, 22
— destructive lesions causing, vi, 267
— rickets causing, vi, 182
— round shoulders and, vi, 270
— spinal tuberculosis and, vi, 87

Labor, abruptio placentæ and, i, 56
— accidents at, i, 4, 7, 8, 9, 130-35
— acidosis at, i, 91, 130-133
— anesthesia during, i, 109, 169
— — convulsions in, i, 38
— — deaths with, acapnia and acidosis causing, i, 130, 131
Labor, anesthesia during, infection caused by, i, 91
— — rectal, cardiac cases and, i, 33
— — tuberculosis and, i, 29
— aseptic preparations at, i, 86, 95 109
— blood-pressure during, shock and, i, 131
— bougie method at, i, 110
— breech delivery, i, 8, 56, 60, 111, 117, 118, 121, 123, 131, 136
— — technic of, i, 128
— care during, ii, 122
— convulsions at, i, 4, 10, 36, 48, 116
— — treatment of, i, 38, 39
— dangers of, i, 150
— decompensation in, treatment of, i, 32, 33
— dystocia in, i, 19, 41
— exhaustion at, breast milk and, i, 141
— forceps delivery, birth palsy in, i, 125
— — cardiac cases and, i, 32, 33
— — clavicular fracture in, i, 121
— — conservatism in, i, 19
— — convulsions after, i, 116
— — falx and tentorium ruptured in, i, 117
— — feeble-mindedness and, i, 111, 112
— — hematoma and, i, 125
— — hemorrhages in bulbar and medullary, i, 120
— — lacerations and, i, 689
— — placenta prævia and, i, 60
— — skull injuries in, i, 116
— hemorrhage during, i, 91, 150
— — brain, newborn, i, 139
— — central nervous system, death at birth and, i, 118, 119, 120
— — cerebral, newborn, i, 111, 112, 113, 137, 150
— — cerebrospinal, breech deliveries and, i, 117
— — dural, birth injuries and, i, 113
— — induction and, premature labor, i, 107
— — intracranial at birth, i, 111, 120
— history of patient and, i, 17
— hospital delivery, i, 5, 90, 157, 158, 162

Labor, hospital delivery, sepsis in, i, 5, 90
— inertia and, i, 91
— infections during, i, 91, 96-105
— — abortion and, i, 6, 43, 47
— — bacteriology of, i, 87
— — blood transfusion and, i, 103, 104
— — census reports of, i, 2
— — charts, illus., i, 100, 102, 114
— — chemical treatment of, i, 104
— — eclampsia and, i, 92
— — endometritis and, i, 93
— — frequency of, i, 90
— — gonococcus causing, i, 61, 94
— — hygienic prevention of, i, 95, 96
— — leukocyte count in, i, 101
— — maternal deaths due ot, i, 86
— — metritis and, i, 93
— — midwives' responsibility in, i, 153
— — miscarriage and, i, 47
— — mortality rates of, i, 90
— — operative treatment of, i, 91, 104
— — pathology of, i, 88
— — placental, i, 91, 94
— — predisposing causes of, i, 91
— — prenatal care and, i, 5, 12
— — protein therapy and, i, 103
— — serums in, i, 99-103
— — specific treatment of, i, 99
— — staphylococcus aureus causing, i, 87
— — streptococcus causing, i, 87
— — symptomatology of, i, 93
— — thrombophlebitis and, i, 94
— — thrombosis and, i, 89
— — treatment of, i, 95-104
— infection of infant during, iii, 11
— injuries at, i, 111, 112
— — cephalic, i, 8, 112
— — clavicular, i, 121, 123, 127
— — extremities and, i, 121
— — infant death due to, i, 7, 8
— — intrapartum, i, 111-129
— — nerves and, i, 124
— — obstetrical management and, i, 8
— — spinal, i, 117
— instructions, i, 95, 169
— lacerations at, i, 45, 88, 91
— — repair of, i, 89, 97
— mania at, acute, i, 40
Labor, midwife's service at, i, 151-154
— operative delivery, i, 91, 104
— — death from sepsis in, i, 90, 91
— — dystocia and, i, 19
— — inertia necessitating, i, 91
— — infections following, i, 87, 90, 91, 104
— — injuries in, i, 111, 128
— — pelvic examination and, i, 19
— — shock prevention and, i, 19
— pains at, i, 109, 169
— — abruptio placentæ and, i, 54, 55
— — acute cystoma and, i, 42
— — breast feeding and, i, 140
— — fibromyomata and, i, 44
— — heart, i, 30, 31
— — lower back, i, 169
— — neuralgic, toxemias and, i, 37
— — premature imitation of, i, 109
— — prenatal care and, i, 45
— pelvic measurements at, i, 18
— placenta prævia and, i, 60
— premature, cardiac cases and, i, 33
— — conservatism and, i, 19
— — death in utero prevented by, i, 49
— — induction of, i, 106-110
— — prenatal care preventing, i, 12, 15, 149
— — syphilis causing, i, 79
— — uterine myomata and, i, 42
— prenatal care and, i, 12, 15, 149
— public health measures, protection of mother and child and, i, 150-175
— rubber bags and, i, 108
— sepsis following accidents of, i, 130-135
— — primary, i, 131
— — secondary, i, 133
— shoulder delivery, i, 121, 122, 123, 128
— — fractures in, i, 127
— — subluxation in, birth palsy due to, i, 124
— — technic of, i, 128
— stillbirths at, autopsy of, i, 9
— — breech deliveries and, i, 117
— — causes of, i, 8
— — census reports of, i, 2
— — cerebral hemorrhage and, i, 112

Labor, stillbirths at, frequency of conception and, i, 6
— — history of patient and, i, 17
— — reduction of, prenatal care and, i, 10, 12, 81, 82, 84
— — spinal injuries and, i, 121
— — syphilis and, i, 63, 64, 77, 79, 84
— — tears and, falx and tentorium, i, 117
— — traumatism and, i, 111
— supplies for, i, 170
— tamponade in, i, 110
— toxemia and, i, 131
— tuberculosis and, i, 20
— tumors at, i, 18, 41-44, 45
— uterine myomata and, i, 42
— version delivery, i, 120, 121, 131
— — abortion and, i, 43
— — Braxton-Hicks, placenta prævia and, i, 60
— — cardiac cases and, i, 33
— — collapse in, i, 131
— — conservatism and, i, 10
— — decompensation and, i, 32
— — internal podalic, placenta prævia and, i, 60
— — spinal injuries, i, 120, 121
— vertex delivery, i, 117, 121
— Wassermann reaction at, i, 76
Laboratory examination, blood examination, xvii, 43
— hereditary syphilis and, xvii, 242
— spinal fluid examination, xvii, 51
— — neurosyphilis and, xvii, 170—*See also* xx.
Labored respiration, significance of, ix, 80
Lacerated wounds, scar contractures following, vi, 201
Lacrimal apparatus, anomalies of, iii 360
Lacrimal glands, Mikulicz' disease affecting, viii, 55
Lachrimal secretion, ii, 110, 114
Lachrimation, lenticular degeneration and, v, 75
Lactalbumin, ii, 145; x, 12; xii, 162, 164
Lactose, ii, 80
— absent in saliva at birth, ii, 84
— prematurity and, ii, 168
Lactose, carbohydrate digestion by, x, 34
Lactation, glycosuria during, xiii, 103
— increased milk yield with progress of, xii, 168
— menstruation and, xii, 190
— nursing the best galactagogue, xii, 169
— pregnancy and, xii, 190
— preparation for, i, 130-148
— standards of successful, xii, 185
— tuberculosis and, xii, 188
Lactic acid, milk acidified with, x, 119
Lactic-acid acidosis, conditions associated with, xx, 171
Lactose, human milk, xii, 162
— infant feeding and, i, 140
— toleration of, xii, 40
Lactosuria, xx, 9
Laennec, tuberculosis studied by, ix, 216
Lagophthalmos, iii, 350
La grippe, synonyms of, xiv, 377
Lamblia intestinalis, infestation with, viii, 300
— morphology and identification of, xx, 78
[illegible] vii, 255
Land scurvy, symptoms of, xvi, 92
Lange colloidal gold test, usefulness of, v, 16; xvii, 55
Languor, newborn, i, 137
Lanugo, description of, ii, 10
— newborn showing presence of, ii, [illegible]
— presence in meconium, ii, 92
La perlèche, xvi, 343
La rage, synonyms of, xiv, 311
Large intestine, development of, x, 66
Larosan, composition of, xii, 98
La rougeole, synonyms of, xiv, 34
Laryngeal diphtheria, foreign bodies in respiratory tract and, ix, 191
— intubation in, xiv, 172
— symptoms of, xiv, 163
Laryngeal stridor, inspiratory, iii, 72
Laryngismus stridulus, character of cough of, ix, 90
— laryngeal obstruction and, ix, 83
— tetany causing, x, 250

Laryngitis, acute, character of cough of, ix, 99
— — clinical types of, ix, 76
— — obstruction caused by, ix, 83
— catarrhal, measles complicated by, xiv, 45
— chronic, obstruction caused by, ix, 83
— croupous, simple, ix, 76
— diphtheritic, ix, 80
— — character of cough of, ix, 99
— simple acute, diagnosis of, ix, 77
— — etiology of, ix, 76
— — simptoms of, ix, 76
— — treatment of, ix, 78
— simple croupous, ix, 76
— spasmodic, diagnosis of, ix, 80
— — etiology of, ix, 79
— — symptoms of, ix, 79
— — treatment of, ix, 81
— traumatic, ix, 83
Laryngospasm, foreign bodies in respiratory tract and, ix, 191
— tetany causing, 250
Larynx, abnormalities of, congenital, ix, 75
— anatomy of, iii, 67; ix, 75
— anomalies of, cyanosis caused by, ii, 205
— congenital abnormalities of, ix, 75
— congenital syphilis and, iii, 58
— diaphragm of, congenital, ix, 76
— diseases of, iii, 70
— — acute laryngitis, ix, 76
— — catarrhal croup, ix, 79
— — catarrhal spasm, ix, 79
— — chronic hyperplastic laryngitis, ix, 81
— — chronic laryngitis, ix, 81
— — croup, ix, 79
— — croupous laryngitis, ix, 79
— — diphtheritic laryngitis, ix, 80
— — simple acute laryngitis, ix, 76
— — simple croupous laryngitis, ix, 76
— — spasmodic croup, ix, 79
— — spasmodic laryngitis, ix, 79
— — syphilis of larynx, ix, 82
— — tuberculosis of, ix, 82
— — tumors of larynx, ix, 82
— edema of, mumps causing, xiv, 148
Larynx, foreign bodies in, ix, 188; xv, 240
— function of, ix, 75
— granuloma of, iii, 72
— infections of, iii, 72
— malformations of, iii, 70; ix, 75
— obstruction of, ix, 83
— — character of cough of, ix, 99
— papilloma of, ix, 82
— physiology of, iii, 67
— spasm of, iii, 74
— syphilis of, ix, 82
— tetany causing spasm of, v, 130
— tuberculosis of, ix, 82; xiv, 350
— — pregnancy and, i, 27, 28
— tumors of, ix, 82
Lassar's paste, formula of, xvi, 347
Late congenital syphilis, pathological evidence of, xvii, 33
Late hereditary syphilis, xvii, 2
— — manifestations of, xvii, 141
Late infancy, diet in, iv, 55
Latent bone rickets, vi, 187
Latent peritonitis, viii, 261
Latent scurvy, x, 222
Latent syphilis, bone stigmata of, xvii, 227
— dental stigmata of, xvii, 212
— incidence of, xvii, 208
— maternal, xvii, 69
— nerve stigmata of, xvii, 226
— ocular stigmata of, xvii, 225
— paternal, xvii, 68
— resistance to reinfection in, xvii, 75
— skin stigmata of, xvii, 229
— stigmata of, combination of, xvii, 230
Lateral branchial cysts, surgery of, xv, 183
Lateral sclerosis, amyotrophic, vii, 251
— Little's disease differentiated from, vi, 240
Lateral ventricle, puncture of, v, 87
Later infancy and childhood, candy in, xii, 139
— convulsions in, xii, 141
— dentition and feeding during, xii, 136
— eating between meals, xii, 138
— immunity and susceptibility in, xii, 140

Later infancy and childhood, intervals in feeding in, xii, 137
— milk changes in, xii, 136
— peculiarities in expression of disease during, xii, 140
— reflexes in, xii, 140
— regularity in feeding in, xii, 137
— selective eaters, xii, 139
Late secondary syphilitic lesions, skin and mucous membranes showing, xvii, 126
Latissimus dorsi, paralysis of, birth and, i, 125
Laughing-gas, labor and, i, 169
La vaccine, synonyms of, xiv, 104
Lavage, gastric, eclampsia and, i, 39
— — methods of, viii, 339; ix, 271
La varicelle, synonyms of, xiv, 69
La variole, synonyms of, xiv, 80
La vérolette, synonyms of, xiv, 69
Laxatives, pregnancy and, i, 25
— therapeutic use of, respiratory diseases and, ix, 262
Laxity, congenital, knee showing, vi, 13
Layette, infant, ii, 127
Lead encephalitis, cerebrospinal fluid in, xx, 115
Lead nipple-shields, i, 143
Lead poisoning, accidental, viii, 313
— anemia caused by, xi, 81; xx, 50
— convulsions following, v, 136
— peripheral nerve injury and, vi, 251
— prematurity caused by, ii, 163
— size of child and, ii, 14
Legs, congenital anomalies of, vi, 278
— fracture of both bones of, xv, 112
— fractures of, newborn, i, 124
— hereditary edema of, xvi, 309
— milk, thrombophlebitis causing, i, 94
— proportions of, ii, 29
Legg's (Perthes') disease, diagnosis, vi, 110; vii, 76
— etiology of, vi, 108; vii, 73
— hip-joint disease differentiated from, vii, 127
— pathology of, vii, 76
— prognosis of, vi, 110
— symptoms of, vi, 109; vii, 76
— treatment of, vi, 110; vii, 77
Legg's (Perthes') disease, tuberculosis of bones and joints differentiated from, vi, 71, 83; vii, 16
— x-ray examination of, vi, 110; vii, 76
Legislation, factory, prenatal care and, i, 156
Leiomyoma fibrosum, inspiratory stridor caused by, iii, 74
Length, average increase in first 2 years in, iv, 25
— newborn, ii, 18
— — fetal age and, ii, 161
— — race and sex influencing, iv, 17
Lens, malformations of, iii, 356, 362
Lenticular and caudate nuclei, anatomy of, v, 71
Lenticular degeneration, athetoid movements in, v, 75
— cirrhosis of liver and, v, 71
— heredity and, v, 61
— hysteria and, v, 170
— physical signs of, v, 74
— prognosis of, v, 72
— results of, v, 71
— typical case of, v, 72
Lenticular nucleus, dystonia, in disease of, v, 1
Lentigo, xvi, 287
Leontiasis ossea, vii, 80
Leprosy, diagnosis of, xvi, 247
— etiology of, xvi, 246
— incidence of, xvi, 243
— maculo-anesthetic, xvi, 246
— newborn, iii, 64
— nodular, xvi, 244
— prognosis of, xvi, 247
— symptoms of, xvi, 244
— treatment of, xvi, 247
— types of, xvi, 244
— vitiligo differentiated from, xvi, 293
Leptomeninges, Buhl's disease causing hemorrhages in, iii, 5
Lésne's scalene sign, ix, 148
Les oreillons, synonyms of, xiv, 141
Lethargic encephalitis, synonyms of, xiv, 254
— — newborn and, iii, 31
Lethargy, breast feeding affected by, ii, 154

Lethargy, complemental feeding demanded by, ii, 156
— cyanosis and, ii, 205
— dehydration fever and, ii, 209
— epidemic encephalitis and, v, 98
— icterus neonatorum and, ii, 219
— infection causing, v, 78
— intracranial hemorrhage and, iii, 239
— sepsis neonatorum and, iii, 15
— "sleeping sickness" causing, v, 98
— symptoms of, ii, 172
— transitory fever and, ii, 209
— Winckel's disease causing, iii, 3
Leucin, presence in meconium, ii, 92
Leucinuria, significance of, xx, 19
Leukemia, acute lymphatic, blood-picture of, xi, 139; xx, 57
— — case history of, xi, 133
— — course of, xi, 141
— — diagnosis of, xi, 140
— — glandular fever differentiated from, xiv, 317
— — physical signs of, xi, 138
— — symptoms of, xi, 137
— — treatment of, xi, 142
— acute myelogenous, blood changes in, xx, 58
— — blood-count of, xi, 152, 154
— — case history of, xi, 150
— — diagnosis of, xi, 155
— — symptoms of, xi, 153
— — treatment of, xi, 155
— leukemic, blood-count in, xi, 163
— — blood-picture of, xi, 165
— — case history of, xi, 162
— — clinical picture of, xi, 165
— — course of, xi, 167
— — diagnosis of, xi, 166
— — treatment of, xi, 168
— — types of, xi, 161
— chronic lymphatic, blood changes in, xx, 58
— — blood-count of, xi, 145, 147
— — case history of, xi, 143
— — diagnosis of, xi, 147
— — symptoms of, xi, 146
— — treatment of, xi, 148
— chronic myelogenous, blood-count of, xi, 158
— — case history of, xi, 156
Lethargy, chronic myelogenous, symptoms of, xi, 159
— — treatment of, xi, 160
— forms of, xi, 129, 161
— frequency in children, xi, 132
— introductory considerations of, xi, 129
— lymphatic, blood-picture of, xi, 100
— — epistaxis and, ix, 18
— newborn, iii, 121
— original report of, xi, 3
— oxidase stain technic in, xi, 29
— prurigo and, xvi, 82
— tissues involved in, xi, 129
Leukocyte count, puerperal infections and, i, 93, 94, 101
Leukocytes, age and possible variation in number of, xi, 38
— average number of, xi, 39
— classification of, xi, 16
— counting of, xi, 25
— differential count of, ii, 70; xx, 35
— formation and origin of, xi, 18
— functions of, xi, 6
— infarct period and, ii, 105
— morphology of, xi, 16
— newborn characteristics of, ii, 68
— number of, xi, 41, 43, 44; xx, 34
— original description of, xi, 2
— significance of abnormalities in, xi, 20
— variation in count of, ii, 69
Leukocytosis, diseases usually presenting, xi, 47
— infancy and childhood and, xv, 50
— lobar pneumonia and, ix, 145, 148
— lung abscess and, ix, 174
Leukoderma acquisitum centrifugum, xvi, 290
— congenital, iii, 345
Leukonychia, xvi, 269
Leukopenia, diseases usually presenting, xi, 51
Leukoplakia, psoriasis resembling, xvi, 125
Leukosarcoma, leukemia and, xi, 130
Levaditi method, spirochetes in liver of syphilitic infants shown by, i, 75
Levulosuria, xx, 9

Leyden-Möbius, hereditary muscular atrophy of, vii, 255
Lichen acuminatus, xvi, 145
Lichenification, diagnosis of, xvi, 141
— etiology of, xvi, 141
— prognosis of, xvi, 141
— symptoms of, xvi, 141
— treatment of, xvi, 141
Lichen nitidus, etiology of, xvi, 239
— pathology of, xvi, 239
— symptoms of, xvi, 239
— treatment of, xvi, 239
Lichen planus, diagnosis of, xvi, 144
— etiology of, xvi, 144
— granuloma annulare differentiated from, xvi, 240
— lichenification differentiated from, xvi, 141
— papular urticaria differentiated from, xvi, 80
— pathology of, xvi, 144
— prognosis of, xvi, 144
— psoriasis differentiated from, xvi, 129
— symptoms of, xvi, 142
— treatment of, xvi, 144
— varieties of, xvi, 143
— vitiligo differentiated from, xvi, 293
Lichen planus atrophicus, xvi, 143
Lichen ruber, xvi, 145
Lichen scrofulosorum, etiology of, xvi, 238
— symptoms of, xvi, 237
— treatment of, xvi, 238
Lichen simplex chronicus, eczema differentiated from, xvi, 118
— synonyms of, xvi, 141
Lichen spinulosus, symptoms and treatment of, xvi, 145
Lichen tropicus, xvi, 277
Lichen urticatus, xvi, 78
Lieberkühn, crypts of, anatomy of, iii, 128
Life, child, functional periods of, x, 72
— — sociological periods of, x, 50
Life periods, iv, 6
Ligaments, affections of, orthopedic, vi, 49
— knee, testing of, vi, 13
Ligation, umbilical cord, ii, 124
Light, artificial, composition of, vii, 217
— — pathogenic microörganisms and, vii, 218
— — rickets treated by, vii, 200
— — sunlight compared with, vii, 219
— dermatitis caused by, xvi, 33, 39
— pupillary reaction at birth to, ii, 114
— sun, artificial light compared with, vii, 219
— — composition of, vii, 217
— — influence of local conditions on, vii, 218
— — pathogenic microörganisms and, vii, 218
— — plant life dependent upon, x, 202
— — rickets treated by, x, 245
— — value of, x, 25
Limewater, care of teeth with, i, 166
Lingua geographica, diagnosis of, xvi, 339
— etiology of, xvi, 339
— prognosis of, xvi, 340
— symptoms of, xvi, 338
— treatment of, xvi, 339
Lingua nigra, xvi, 340
Lingual tonsils, anatomy of, ix, 50
— function of, ix, 50
Lip, chancre of, xvii, 234
— herpes of, viii, 12
Lipase, ii, 87
— fat digestion and, x, 30
Lipoidnephrosis, syphilis as a cause of, xix, 80
Lipoma, atheroma differentiated from, xvi, 282
— diagnosis of, xvi, 328
— etiology of, xvi, 328
— joints and, vi, 126
— pathology of, xvi, 328
— prognosis of, xvi, 328
— symptoms of, xvi, 327
— treatment of, xvi, 328
Lipuria, significance of, xx, 12
Liquor amnii, fetal death in utero and, i, 50
— infant mortality and infection of, iii, 11
— newborn and, i, 136

Literature, pediatric, ii, 1; iv, 3
Lithiasis, hematuria and, xix, 70
— urinary, clinical features of, xv, 362
— — treatment, xv, 363
Little's disease, etiology of, vi, 237
Livedo reticularis, passive hyperemia and, xvi, 56
Liver, abscess of, pleurisy following, ix, 193
— acute yellow atrophy of, Buhl's disease resembling, iii, 4
— anatomy of, iii, 128
— angioma of, iii, 201
— Buhl's disease causing fatty degeneration of, iii, 4
— carcinoma of, iii, 201
— circulation of, newborn, i, 138
— cirrhosis of, lenticular degeneration and, v, 71
— conditions of, pregnancy and, i, 21
— congenital and familial icterus and, iii, 200
— congenital malformation of, iii, 199
— congenital syphilis causing enlargement of, iii, 48, 58
— cysts of, iii, 201
— development of, x, 67, 74, 76, 77
— diseases of, iii, 199
— — benign jaundice from roundworms, viii, 328
— — catarrhal jaundice, viii, 326
— — cirrhosis, viii, 330
— — fatty degeneration, viii, 330
— — hepatic insufficiency, viii, 327
— — hydatid disease, viii, 330
— — infectious hepatitis, viii, 325
— — leucin and tyrosin in, xx, 19
— — urobilinuria in, xx, 11
— early life disturbances of, viii, 325
— enlargement of, heart failure and, i, 30; xviii, 50
— — spleen enlargement and, syphilis and, i, 75
— functions present at birth, ii, 88
— gumma of, illus., i, 92
— hemorrhage of, iii, 199
— icterus causing necrotic areas in, ii, 224
— injuries of, iii, 199
Liver, lobular cells in icterus, ii, 220
— lymph connection with mammary gland, ii, 141
— malaria causing changes in, xiv, 212
— newborn, iii, 128
— parenchymatous disease of, iii, 199
— physiology of, ii, 88; viii, 324
— rupture of, iii, 187
— sarcoma of, iii, 200
— sepsis and, i, 92
— size of newborn, ii, 88, 213
— surgical aspects of jaundice, xv, 330
— syphilis of, i, 75, 80
— — early manifestations of, xvii, 140
— — pathological evidence of, xvii, 28
— syphilitic infants and, i, 73-75
— tuberculosis of, iii, 62; xiv, 354
— tuberculosis of, relative frequency of, ix, 231
— tumors of, iii, 200; viii, 325; xv, 334
— typhoid pathology and, viii, 186
— umbilical hernia caused by enlargement of, iii, 158
Liver spots, xvi, 288
Livid asphyxia, ii, 197
Living conditions, infant mortality and, i, 3, 4
Lobar pneumonia, abdominal distention in, treatment of, ix, 165
— abdominal type of, ix, 152
— abortive type of, ix, 149
— acute appendicitis differentiated from, viii, 253
— associated conditions in, ix, 158
— bacteriology of, ix, 137
— blood-count in, xi, 47, 48
— blood picture in, ix, 145
— bowel care in, ix, 16
— bronchopneumonia simulating, ix, 123
— cerebral type of, ix, 150
— character of cough in, ix, 144
— chicken-blood therapy in, ix, 167
— clinical picture of, ix, 140
— clinical types of, ix, 149
— complications of, ix, 159

Lobar pneumonia, concealed type of, ix, 151
— congestion stage of, ix, 138
— counterirritation in, ix, 163
— course of, ix, 152
— diagnosis of, ix, 153
— diathermy in, ix, 167
— diet in, ix, 164
— empyema differentiated from, ix, 200
— etiology of, ix, 140
— gastro-intestinal disturbances in, ix, 145
— gray hepatization stage of, ix, 139
— heart complications in, xviii, 190
— heart stimulation in, ix, 166
— herpes simplex and, xvi, 87
— hydrotherapy in, ix, 164
— inhalations in, ix, 166
— leukocytosis in, xx, 47
— mercurochrome in, ix, 167
— migratory type of, ix, 149
— nervous disturbances in, ix, 146
— oxygen in, ix, 165
— pain in, ix, 144
— pathology of, ix, 138
— physical signs in, ix, 146
— primary nature of, ix, 140
— prognosis of, ix, 152
— — Morgan's, ix, 161
— prolonged type of, ix, 149
— pulse in, ix, 142
— red hepatization stage of, ix, 139
— resolution of, ix, 139
— respiration in, ix, 143
— rheumatic fever complicated by, xviii, 39
— rheumatic infections and, xviii, 79
— scalene sign in, ix, 148
— serum treatment of, ix, 167
— short duration type of, ix, 149
— skin symptoms in, ix, 144
— stages of, ix, 138
— symptoms of, ix, 140
— — unfavorable, ix, 148
— temperature in, ix, 141
— treatment of, ix, 160
— typical signs of, ix, 153
— unresolved, pulmonary tuberculosis differentiated from, xiv, 352
— urine in, ix, 145
Lobsters, contra-indicated in diet of pregnancy, i, 24
Lobular pneumonia, ix, 121
Local head injuries, xv, 164
Localization, cortical, v, 3
Localized osteomyelitis, clinical signs of, vii, 71
— complications of, vii, 71
— sequelæ of, vii, 73
— treatment of, vii, 72
— x-ray diagnosis of, vii, 72
Localized pressure, tuberculosis of spine causing, v, 123
Localized scleroderma, xvi, 304
Lochia, colon bacillus infection producing, i, 77
— endometritis and, i, 93
— infectiousness of, i, 86
— postpartum care of, i, 161
— puerperal sepsis and, i, 93
Lockjaw, synonym of, xiv, 296
Locomotion, inauguration of, iv, 66
Locomotor ataxia, Friedreich's ataxia differentiated from, vi, 250
Longitudinal sinus, cyanosis and oxygen unsaturation in blood of, ii, 204
— puncture of, danger of, v, 82
Lorain infantilism, diagnosis of, xiii, 146
— general considerations of, x, 139
— metabolism of, xiii, 145
— prognosis of, xiii, 47
— signs and symptoms of, xiii, 145
— treatment of, xiii, 147
Lordosis, albuminuria and, xix, 61
— compensatory lumbar, vi, 17, 19
— congenital, iii, 282; vii, 50
— definition of, vi, 22
— pseudohypertrophic dystrophy showing, v, 604
— spinal tuberculosis and, vi, 88
Lorenz' bloodless operation, congenital dislocation of hip-joint and, vii, 60
Loss of weight, physiologic, of newborn, ii, 34, 39
Lotio alba, formula of, xvi, 348
Lotions, skin, xvi, 346
Louse, body, xvi, 156

Louse, chicken, xvi, 159
— head, xvi, 155
— pubic, xvi, 157
Love, development of, iv, 69; x, 73
Low-grade joint affections, orthopedic management of, vi, 68, 98
Lower extremities, congenital malformations of, vii, 57
— development of, x, 60, 76
Lucilia cæsar, poliomyelitis and, xiv, 229
Lues, blood changes in, xx, 48
— congenital, nasal manifestations of, ix, 15
— *See also* Syphilis
Luetic meningitis, cerebrospinal fluid in, xx, 103
Luetic nephritis, acute, blood chemistry in, xx, 147
— *See also* Syphilitic
Lumbago, rare in childhood, vii, 123
Lumbar puncture, anatomical factors in, vii, 8
— anesthesia and, v, 88
— brain tumors and, v, 118
— contra-indications of, v, 18, 84
— epidemic encephalitis and, v, 99
— hemorrhage accelerated by, v, 84
— herniation of medulla following, v, 18
— intracranial hemorrhage and, 44
— intracranial pressure at birth and, i, 113
— location of, v, 87
— method of therapeutic use of, respiratory diseases and, ix, 279
— pressure reduction by, v, 44
— technic of, v, 86; xx, 97
Luminal, epilepsy treated with, v, 139
— sedative use of, respiratory diseases and, ix, 264
— tachycardia and, i, 33
Lung fever, ix, 137
Lungs, abscess of, characteristic appearance of sputum in, xx, 84
— — clinical course of, xv, 238
— — clinical features of, xv, 237
— — diagnosis of, ix, 175; xv, 238
— — etiology of, ix, 172; xv, 236
— — exploratory puncture in, ix, 174
— — foreign bodies causing, ix, 191
Lungs, abscess of, insufflation pneumonia causing, ix, 179
— — lobar pneumonia causing, ix, 160
— — pathology of, ix, 173
— — physical signs of, ix, 174
— — prognosis of, xv, 239
— — symptoms of, ix, 173
— — treatment of, ix, 176; xv, 239
— — x-ray examination in, ix, 175
— ambiosis of, ix, 186
— anatomy of, ix, 85
— angioma of, ix, 187
— capacity of, rheumatic fever diminishing, xviii, 55
— chest examination, ix, 87
— chronic congestion of, heart disease and, xviii, 126
— cough, interpretation of, ix, 98
— cyst of, ix, 187
— diseases of, abscess of the lung, ix, 172; see also under Lungs, abscess of
— — acute asthmatic bronchitis, ix, 109
— — acute bronchitis, ix, 101
— — acute bronchopneumonia, ix, 121
— — acute catarrhal bronchitis, ix, 101
— — acute pneumonia, ix, 137
— — acute spasmodic bronchitis, ix, 109
— — allergic coryza, ix, 117
— — American autumn fever, ix, 117
— — angioma, ix, 187
— — aspiration pneumonia, ix, 176
— — asthma, ix, 109
— — autumn fever, ix, 117
— — bronchial asthma, ix, 109
— — bronchial catarrh, ix, 107
— — bronchial croup, ix, 106
— — bronchopneumonia, ix, 121
— — catarrhal pneumonia, ix, 121
— — chest cold, ix, 101
— — chronic bronchitis, ix, 107
— — chronic interstitial pneumonia, ix, 168
— — chronic phthisis, ix, 241
— — chronic pneumonia, ix, 168
— — chronic pulmonary tuberculosis, ix, 241
— — chronic tuberculous pneumonia, ix, 241

Lungs, diseases of, chronic ulcerative tuberculosis, ix, 241
— — croupous pneumonia, ix, 137
— — cyst of, ix, 187
— — deglutition pneumonia, ix, 176
— — edema of, i, 32
— — emphysema, ix, 184
— — fibrinous bronchitis, ix, 106
— — fibrinous pneumonia, ix, 137
— — gangrene, ix, 182; xx, 84
— — hay-fever, ix, 117
— — hypostatic pneumonia, ix, 171
— — insufflation pneumonia, ix, 176
— — interstitial pneumonia, ix, 168
— — lobar pneumonia, ix, 137
— — lobular pneumonia, ix, 121
— — lung fever, ix, 137
— — massive pneumonia, ix, 137
— — miliary tuberculosis, ix, 236
— — parasitic infestation, ix, 185
— — peripneumonia, ix, 137
— — plastic bronchitis, ix, 106
— — plastic pneumonia, ix, 137
— — pleuropneumonia, ix, 137
— — pneumonia, chronic, ix, 168
— — — hypostatic, ix, 171
— — — insufflation, ix, 176
— — — lobar, ix, 137
— — — postoperative, ix, 176
— — pollen fevers, ix, 117
— — pollinosis, ix, 117
— — pulmonary tuberculosis, ix, 236
— — syphilis of, xvii, 140
— — teniasis of, ix, 186
— — tracheobronchitic, ix, 101
— — tuberculosis of, xiv, 350
— — tuberculous bronchitis, ix, 237
— — tuberculous bronchopneumonia, ix, 238
— — tuberculous pleurisy, ix, 243
— — vasomotor rhinitis, ix, 117
— edema of, pregnancy and, i, 32
— excretion of acids by, xx, 168
— foreign bodies in, xv, 240
— gangrene of, characteristic appearance of sputum in, xx, 84
— — diagnosis of, ix, 183
— — etiology of, ix, 182
— — insufflation pneumonia causing, ix, 179
— — lobar pneumonia causing, ix, 160
Lungs, gangrene of, pathology of, ix, 182
— — symptoms of, ix, 183
— — treatment of, ix, 183
— growth of, x, 71, 74, 77
— — heart failure and, i, 30
— infarcts of, heart disease and, xviii, 127
— lymphatics of, ix, 85
— newborn, i, 136
— — anatomy of, iii, 68
— — Buhl's disease causing fatty degeneration of, iii, 4
— — congenital absence of, iii, 81
— — congenital syphilis and, iii, 58
— — hemorrhages of, iii, 82
— — infections by way of, iii, 12
— — injuries of, iii, 82
— — malformations of, iii, 81
— — physiology of, iii, 68
— — tumors of, iii, 86
— parasitic infestation of, ix, 185
— percentage of alveolar air in, i,, 53
— rheumatic infection of, pathology of, xviii, 39
— syphilis of, early manifestations of, xvii, 140
— — incidence of, xvii, 168
— — pathological evidence of, xvii, 27
— — sthenic pneumonia, ix, 137
— teniasis of, ix, 186
— tuberculosis of, xiv, 350
— — acute bronchitis and, ix, 101
— — character of cough of, ix, 100
— — chronic phthisis, ix, 241
— — chronic pulmonary tuberculosis, ix, 241
— — chronic tuberculous pneumonia, ix, 241
— — chronic ulcerative tuberculosis, ix, 241
— — cough as a symptom of, ix, 228
— — miliary, ix, 236
— — pleurisy with effusion caused by, ix, 195
— — relative frequency of, ix, 231
— — tuberculous bronchitis, ix, 237
— — tuberculous bronchopneumonia, ix, 238
— — tuberculous pleurisy, ix, 243

Lungs, vital capacity of, enlarged non-tuberculous bronchial glands and reduction of, ix, 209
— volume of, ii, 53
Lupus, multiple disseminated, measles followed by, xvi, 226
Lupus erythematosus, diagnosis of, xvi, 242
— etiology of, xvi, 242
— hydroa vacciniforme differentiated from, xvi, 97
— pathology of, xvi, 242
— prognosis of, xvi, 243
— symptoms of, xvi, 241
— treatment of, xvi, 242
Lupus erythematosus disseminatus, xvi, 243
Lupus follicularis disseminatus, xvi, 226
Lupus vulgaris, characteristics of, xiv, 344
— — derivation of the term, xvi, 224
— diagnosis of, xvi, 228
— etiology of, xvi, 227
— granulosis rubra nasi differentiated from, xvi, 278
— pathology of, xvi, 228
— prognosis of, xvi, 230
— symptoms of, xvi, 225
— treatment of, xvi, 228
Lutein injection, nausea of pregnancy and, i, 25
Lymph, mammary gland supply of, ii, 141
Lymphadenitis, acute, blood-count in, xi, 47
— retropharyngeal, viii, 43
— tuberculous, retroperitoneal and mesenteric, xv, 302
Lymphadenoma, mediastinal, iii, 96
Lymphangioma circumscriptum, xvi,
Lymphangiomata, cervical, xv, 197
— facial, surgery of, xv, 173
— salivary gland, viii, 54
— surgical aspects of, xv, 62
Lymphatic cysts, cervical, xv, 197
— surgical aspects of, xv, 63
Lymphatic glands, anemias associated with disturbances of, xi, 98
— bronchial, bronchopneumonia involving, ix, 126
— — tuberculosis of, ix, 247
Lymphatic glands, enlarged non-tuberculous bronchial, ix, 206
— newborn, iii, 397
— — inspection after birth, ii, 135
— pulmonary, ix, 85
— syphilitic involvement of, early manifestations of, xvii, 139
— tuberculosis of, ix, 244
— — bronchial glands, ix, 247
— — cervical glands, ix, 245
— — general treatment of, ix, 251
— — hilus tuberculosis, ix, 247
— — mesenteric glands, ix, 250
— — tabes mesenterica, ix, 250
Lymphatic leukemia, acute form of, xi, 133
— acute blood changes in, xx, 57
— — blood-picture of, xi, 139
— — course of, xi, 141
— — diagnosis of, xi, 140
— — glandular fever differentiated from, xiv, 318
— — physical signs of, xi, 138
— — symptoms of, xi, 137
— — treatment of, xi, 142
— blood-picture of, xi, 100
— chronic, blood changes in, xx, 58
— — blood-count of, xi, 145, 147
— — case history of, xi, 143
— — diagnosis of, xi, 147
— — symptoms of, xi, 146
— — treatment of, xi, 148
— epistaxis and, ix, 18
Lymphatic nevi, xvi, 5
Lymphocytes, age and possible variation in number of, xi, 38
— formation and origin of, xi, 19
— morphology of, xi, 17
— oxidase stain and, xi, 29
Lymphosarcoma, leukemia and, xi, 130
— mediastinal ix, 211
— — radium treatment of, ix, 214
Lysis, bronchopneumonia terminating in, ix, 129
Lysol, pregnancy and labor and, i, 108, 109, 160

Maceration, fetal death and, i, 48
— syphilitic infants and, i, 75

Macewen's sign, v, 10, 118
Macrogenitosomia præcox, pineal tumor and, xiii, 74
Macroglossia, iii, 130; viii, 5
— treatment of, xv, 175
Macrophages, functions of, xi, 6
Macrostomia, treatment of, xv, 173
Maculo-anesthetic leprosy, xvi, 246
Maculo-fibrinous stomatitis, viii, 24
Maculopapular skin lesions, syphilitic infants and, i, 75
Magnesia, acute laryngitis and, ix, 78
— laxative use of, respiratory diseases and, ix, 262
— milk of, nausea and, i, 25
— — teeth with, care of, i, 166
Magnesium salts, digestion and metabolism of, x, 40
Magnesium sulphate, tetanus neonatorum and, iii, 34
Majocchi's disease, angioma serpiginosum differentiated from, xvi, 298
— telangiectasia in, xvi, 295
Malaria, acute bronchitis and, ix, 102
— anemia caused by, xx, 50
— anemia secondary to, xi, 77
— blood-count in, xi, 51
— chloasma occurring in, xvi, 288
— chronic, xiv, 217
— definition of, xiv, 209
— diagnosis of, xiv, 218
— empyema and, ix, 201
— epistaxis and, ix, 18
— erythema nodosum following, xvi, 64
— etiology of, xiv, 209
— fever associated with, xiii, 39
— history of, xiv, 209
— icterus index in, xx, 40
— leukocyte count in, xx, 47
— malnutrition and, iv, 153
— medicinal treatment of, xiv, 220
— newborn and, iii, 34, 35
— pathology of, xiv, 212
— preventive treatment of, xiv, 219
— prognosis of, xiv, 218
— Public Health regulations for, xiv, 221
— quinin in treatment of, xiv, 220
— symptoms of, xiv, 217
— synonyms of, xiv, 209
Malaria, tertian, treatment of paresis by inoculation with, xvii, 267
— treatment of, xiv, 219
— urobilinuria in, xx, 11
Maldevelopment, fetal placental infarcts causing, v, 141
Male genital organs, anatomy of, xix, 18
— anomalies and malformations of, iii, 260
— congenital anomalies of, ectopic testis, xix, 211
— — epispadias, xix, 214
— — hydrocele, xix, 212
— — hypospadias, xix, 213
— — narrowing of meatus, xix, 215
— — obstruction of urethra, xix, 215
— — paraphimosis, xix, 214
— — phimosis, xix, 214
— diseases of, acute orchitis, xix, 216
— — balanitis, xix, 219
— — balanoposthitis, xix, 219
— — epididymitis, xix, 219
— — malignant tumor of testis, xix, 218
— — syphilis of testis, xix, 218
— — tuberculous orchitis, xix, 216
— — ulcerated meatus, xix, 220
— — urethritis, xix, 219
Malformations, anal and rectal, xv, 342
— birth, hereditary syphilis and, i, 67
— — infant care due to, i, 7
— body proportions of newborn and, ii, 30
— cardiac, congenital, xviii, 4, 129, 130, 138, 184
— congenital, infant mortality and, iv, 111
— kidney, embryological considerations of, xix, 8
— mortality of newborn due to, ii, 3
— teeth, iv, 89

Malignancy, nursing and, iv, 48
— xeroderma pigmentosum and, xvi, 21
Malignant bone tumors, childhood types of, vii, 162

Malignant bone tumors, classification of, xv, 127
— clinical picture and, xv, 128
— diagnosis of, vii, 164; xv, 128
— endothelioma, vi, 199
— general features of, vii, 161
— myeloma, vi, 200
— nomenclature of, vi, 196
— periosteal sarcoma, vi, 197
— rare in infancy, vii, 212
— symptoms of, vii, 162
— treatment of, vii, 165; xv, 129
Malignant diphtheria, symptoms of, xiv, 164
Malignant endocarditis, etiology of, xviii, 186
Malignant hypernephroma, xiii, 94
Malignant newgrowths of skin, xvi, 331
Malignant scarlet fever, xiv, 17
Malingering, skin eruptions and, xvi, 54
Malnutrition, accessory nasal sinus disease and, ix, 34
— actual cause of death in, x, 215
— acute bronchitis and, ix, 102
— adenoids and, iv, 158; ix, 71
— age and endurance of, x, 204
— albuminuria resulting from, xx, 6
— anemia secondary to, xi, 64
— animal experimentation in, x, 199
— asphyxia and, x, 216
— body habitus and, v, 161
— bronchopneumonia and, x, 216
— caloric value of various foods in treatment of, x, 192
— cardiac disease and, iv, 160
— carious teeth and, iv, 160
— causes of, iv, 151; x, 187
— — among older children, iv, 156
— characteristics of, xii, 6
— chronic, fat intolerance and, x, 31
— chronic infections and, iv, 162
— chronic tonsillitis and, ix, 59
— constipation and, iv, 161
— definition of, iv, 150
— diagnosis of, xiii, 143
— dietary treatment of tuberculosis and, x, 196, 198
— ear infections and, iv, 153
— effects of, x, 199
Malnutrition, effects of, prophylaxis and, x, 217
— emotions and, iv, 164
— enlarged non-tuberculous bronchial glands and, ix, 207
— environmental causes of, iv, 162
— fatigue and, iv, 163
— gastro-intestinal infections and, iv, 153
— heart disease and, iv, 152
— heredity and, iv, 12
— inanition and, x, 155
— infantile, extent of, iv, 150
— infantilism and, x, 140
— inherited constitutional defects and, iv, 161
— malaria and, iv, 153
— malocclusion of teeth and, iv, 160
— marasmus and, x, 164
— mental development and, x, 107
— metabolism of, xiii, 141
— muscle affected by, x, 216
— muscle tone deficiency and, iv, 161
— obstructed nasal breathing and, iv, 157, 160
— older children and, x, 170
— period of endurance of, x, 207
— plant life restricted by, x, 200
— posture and, iv, 35; x, 217
— preschool age, iv, 154
— prevention of, iv, 149
— prophylaxis of, xiii, 143
— recovery from, x, 207
— school age, iv, 154
— signs of, x, 170; xiii, 139
— — digestive system, x, 181
— — general appearance, x, 181
— — mental characteristics, x, 179
— — muscles and tendons, x, 178
— — nervous system, x, 179
— — posture, x, 183
— — susceptibility to disease, x, 183
— — weight, x, 172
— suggested day's diet list, x, 195
— symptoms of, xiii, 139
— syphilitic, iv, 153; xvii, 139
— — diagnosis of hereditary type of, xvii, 245
— — treatment of, xvii, 281
— tonsillectomy in, ix, 63
— tonsils and, iv, 159

Malnutrition, treatment of, x, 189; xiii, 143
— tuberculosis and, iv, 144, 153
— ultimate results of, x, 199
— undernutrition in infancy, x, 161
Malocclusion of teeth, viii, 68
— malnutrition and, iv, 160
Malrotation, anomalies due to, iii, 155
Malt preparations, xii, 41
Malt soup extract, xii, 41, 43
Malt sugar, digestion of, xii, 48
— relative value of, xii, 88
Maltase, ii, 89
— absent in saliva at birth, ii, 84
— carbohydrate digestion by, x, 34
Malted milk, xii, 41, 42
Maltose, various foods containing, xii, 41
Malunion of orthopedic considerations, vi, 169
Malunited fractures, vi, 169
Mammary glands, i, 140
— anatomy of, ii, 139; xii, 156
— blood supply of, ii, 140
— deficient gland tissue in, ii, 153
— development of, x, 68, 77
— early presence of secretion in, ii, 110
— hypertrophy of, cause of, ii, 142
— inflammation of, treatment of, xv, 224
— lymph supply of, ii, 141
— nerve supply of, ii, 141
— newborn, iii, 398
— physiology of, ii, 141; xii, 156
Mania, acute, pregnancy and, i, 40
Manipulation, obstetrical, infections following, i, 87, 88, 90, 91
Manometer, v, 43, 88
Mantoux test, allergy and, xiv, 336
— technic of, xiv, 360
Manual expression of breast milk, technic of, iv, 46
Marantic infants, nutritional characteristics of, xii, 6
Marasmus, blood-sugar and, xx, 161
— etiology of, x, 164
— pathology of, x, 165
— prognosis of, x, 167
— symptoms of, x, 165
— treatment of, x, 168
Marble bones, vi, 191
Mare's milk, chemical composition of, xii, 10
Marie, hereditary cerebellar ataxia of, v, 70
Marital relations, abortion and, i, 45
— postpartum care and, i, 161
— retrodisplacement and, i, 20
— sepsis and, i, 95
— syphilitics', regulation of, i, 67, 81
Marriage, epilepsy and, v, 140
— hemophilia and, iv, 10
— Huntington's chorea and, iv, 10
Marrow, composition of, vii, 5
— — postnatal changes in, vii, 5
— tuberculosis causing changes in, vii, 114
Martin knee extension, vi, 208
Masern, synonyms of, xiv, 34
Massage, asphyxia neonatorum and, ii, 201
— cerebral palsies and, v, 146
— flat nipple remedied by, ii, 152
Massive bone graft, ununited fractures and, vi, 174
Massive pneumonia, ix, 137
Mastitis, iii, 399
— treatment of, i, 147; xv, 224
Mastoiditis, acute rhinitis causing, ix, 6
— scarlet fever complicated by, xiv, 20, 30
Masturbation, v, 202
— education and, iv, 99
— enuresis and, xix, 48, 50
Maternal care, ii, 121
— importance during labor, ii, 122
Maternity Center Association of N. Y., exhibit, illus., i, 173
— prenatal care by, i, 11-13
Maternity clothes, i, 162
Maternity corsets, i, 163
— prenatal care and, i, 15
Maternal death, acute yellow atrophy causing, syphilis and, i, 80
— anesthesia causing, acidosis and, i, 130, 131
— asepsis and, i, 86
— cesarean section and, i, 92
— conception causing, frequency of, i, 6

Maternal death, eclampsia and, i, 39, 92
— midwives' responsibility for, i, 153
— milk leg and, i, 94
— miscarriage and, i, 47
— obstetrical technic and, i, 150
— placenta and, manual removal of, sepsis in, i, 97
— puerperal sepsis and, i, 4, 86, 90
— — mercurochrome injections in, i, 104
— — serum treatment of, i, 101
— rates of, i, 2-5
— — causes of, i, 4
— — prenatal care and, i, 10-13, 90
— — sepsis and, i, 98
— — toxemias and, i, 4
— shock at labor and, i, 130
— — acidosis in, i, 131
— thrombophlebitis and, i, 104
Maternal germ, syphilis transmitted by, xvii, 65
Maternal welfare movement, i, 153, 154, 174, 176
Maternity hospital service, i, 157, 158
Maternity nursing, i, 157, 161, 165, 174
— factory day nurseries and, i, 156
— prenatal care and, i, 10
— Public Health and, i, 157
— training for, i, 159
Maternity protection, campaign in New York City, i, 155
— Public Health aspect of, i, 150-175
Mattress, infant's, ii, 131
Matzoon, preparation of, xii, 37
Maxillary sinus, examination of, ix, 22
Meals, eating between, xii, 138
— psychology of infancy and, xii, 151
Measles, acute bronchitis and, ix, 101
— acute follicular tonsillitis differentiated from, ix, 54
— adenoids and, ix, 68
— blood-count in, xi, 51
— bronchopneumonia following, ix, 122, 130
— character of cough of, ix, 101
— chronic bronchitis following, ix, 107
— chronic rhinitis following, ix, 9
Measles, clinical varieties of, xiv, 44
— complications of, xiv, 45
— convalescent serum and, iv, 137
— definition of, xiv, 34
— diagnosis of, xiv, 48
— differential diagnosis of, xiv, 48
— epidemiology of, xiv, 37
— epistaxis and, ix, 18
— eruption of, xiv, 42
— erythema infectiosum differentiated from, xiv, 323
— erythema nodosum following, xvi, 64
— erythema scarlatiniforme and, xvi, 59
— etiology of, iv, 137; xiv, 35
— fetal death and, i, 48
— futility of quarantine of, iv, 130
— general treatment of, xiv, 57
— German, blood-count in, xi, 47
— — erythema multiforme differentiated from, xvi, 62
— — leukocyte count in, xx, 47
— German measles differentiated from, xiv, 66
— history of, xiv, 34
— immunization by virus inoculation, xiv, 56
— incubation period of, xiv, 38
— infant mortality and, iv, 111
— infection of fetus with, iii, 10
— influenza differentiated from, xiv, 383
— isolation in the home, xiv, 53
— leukocyte counts in, xx, 46
— livedo reticularis and, xvi, 57
— lupus vulgaris following, xvi, 226
— mortality of, iv, 136
— nephrosis and, xix, 80
— newborn and, iii, 26
— newborn immunity to, iii, 27
— pathology of, xiv, 38
— prematurity caused by, ii, 163
— preschool age, iv, 137
— preventive treatment of, xiv, 52, 56
— prognosis of, xiv, 49
— protective inoculation and, xiv, 54
— Public Health regulations for, xiv, 59
— pulmonary tuberculosis predisposition following, xiv, 35

Measles, rheumatic infections and, xviii, 78
— scarlet fever differentiated from, xiv, 18
— schools and kindergartens and, xiv, 54
— sequelæ of, xiv, 45
— smallpox differentiated from, xiv, 94
— susceptibility to, iv, 128; xiv, 36
— symptoms of, xiv, 38
— synonyms of, xiv, 34
— treatment of, iii, 27; xiv, 52, 57
— tuberculin test negatived by, ix, 231
— tuberculosis and, iv, 145
— vaginitis associated with, xix, 229
— varieties of, xiv, 44
— whooping-cough predisposing to, xiv, 126
Measurements, before and after birth, ii, 42
— fetal, x, 44
— mental, iv, 78
— pelvic, prenatal care and, i, 18
— psychometric, iv, 81
Meat, bottle feeding supplemented by, xii, 133
— caloric value of, x, 192
— chemical composition of, x, 286
— diet of pregnancy and, i, 23, 165
— milk impairing gastric digestion of, xii, 130, 134
— normal child and, x, 124
— vitamin content of, x, 285
Meatus, congenital stenosis of, xv, 354
— narrowing of, complications of, xix, 215
— ulcer of, xv, 355
— — treatment of, xix, 220
Mechanical agents, dermatitis caused by, xvi, 33
Mechanical vomiting, viii, 92
Meckel's diverticulum, cause of, iii, 164
— cysts caused by, iii, 194
— disturbances of, viii, 245
— incidence of, xv, 281
— intussusception and, xv, 314
— treatment of, iii, 165
Meconium, asphyxia shown by vertex position passage of, ii, 197
Meconium, prematurity and, ii, 165, 168
— sterile at birth, ii, 118
— types of, ii, 91
— water content of, ii, 91
— weight loss and, ii, 37
Mediastinitis, xv, 246
Mediastinum, abscess of, xv, 246
— bronchial lymph-nodes in, whooping-cough and enlargement of, xiv, 124
— diseases of, enlarged non-tuberculous bronchial glands, ix, 206
— — tumors, ix, 211
— non-tuberculous bronchial glands of, enlarged, ix, 206
— tumors of, iii, 96; xv, 247
— — diagnosis of, ix, 212
— — incidence and variety of, ix, 211
— — symptoms of, ix, 212
— — treatment of, ix, 214
Medical care, need for improvement in, childbirth and, i, 150-154
Medical complications, pregnancy and, i, 5, 25, 62
Medical examination, pregnant patient and, i, 17
Medical supervision plan, pregnant patient and, i, 161
Medical teaching, improvement in, maternal protection and, i, 150
Medulla oblongata, delayed speech due to nuclear involvement of, v, 196
— disorders of, v, 216
— "heat center" in, ii, 50
— icterus and, ii, 223
— lumbar puncture and, v, 119
— respiratory function of, v, 119
Medullary hemorrhages, newborn, i, 118, 119, 120
Medullary poliomyelitis, vi, 218
Megacephalus, general considerations of, iii, 214
— newborn, ii, 172
— prematurity contributing to, ii, 164
Megacolon, xv, 2, 322
— cause of, iii, 152
— congenital, viii, 239
— — character of stools in, xx, 73
— constipation and, xii, 126

Megacolon, diagnosis of, iii, 154
— treatment of, iii, 155
Megakaryocytes, platelets and, xi, 21
Megalerythema epidemicum, synonyms of, xiv, 320
Megaloblasts, characteristics of, xi, 12
— significance of, xi, 16
Mehlnährschaden, viii, 142
Melancholia, acute, pregnancy and, i, 40
Melanin, hyperpigmentation due to, xvi, 284
Melanoma, diagnosis of, xvi, 334
— etiology of, xvi, 334
— incidence of, xvi, 334
— treatment of, xvi, 335
Melena, bleeding in newborn or, viii, 109
— peptic ulcer of duodenum and, viii, 146
Melena spuria, hemorrhage in, iii, 185
Mellin's Food, xii, 41, 43
Membrane, diphtheritic, nasal, ix, 16
— premature rupture of, result of, ii, 162
— rupture of, infection following, i, 96
— schneiderian hemorrhage from, ix, 17
— — hyperplasia of, ix, 12
— — structure of, ix, 1
— synovial, tuberculosis causing changes in, vii, 114
Membranous bone formation, diseases of, fragilitus ossium, vii, 29
— — osteogenesis imperfecta, vii, 29
— — osteomalacia, vii, 45
— — osteopsathyrosis, vii, 29
Membranous croup, measles complicated by, xiv, 45
Memory, development period of, x, 73
Men, incidence of syphilis among, xvii, 88
Meningeal hemorrhage, gross, v, 42
Meninges, tuberculosis of, relative frequency of, ix, 231
Meningismus, v, 97
— blood-count in, xi, 49
— cerebrospinal fluid in, xx, 100
Meningismus, cerebrospinal meningitis differentiated from, xiv, 281
— lobar pneumonia causing, ix, 146
— mumps and, xiv, 148
Meningitic poliomyelitis, vi, 218
Meningitis, basilar, cerebrospinal fluid in, xx, 112
— bronchopneumonia and, ix, 130
— cerebrospinal, v, 84
— — bacteriology of, xiv, 266, 280
— — blood-count in, xi, 47
— — clinical types of, xiv, 276
— — complications of, xiv, 282, 291
— — congenital syphilis and, iii, 49
— — convulsions and, v, 137
— — definition of, xiv, 265
— — diagnosis of, xiv, 280
— — dissemination of, xiv, 268
— — epidemic encephalitis differentiated from, xiv, 261
— — epistaxis and, ix, 18
— — etiology of, v, 85; xiv, 269
— — herpes simplex and, xvi, 86
— — history of, xiv, 265
— — hydrocephalus caused by, v, 114
— — incubation period of, xiv, 270
— — laboratory findings in, xiv, 278
— — lumbar puncture in, v, 86
— — meningococcus causing, v, 89
— — pathology of, xiv, 271
— — prognosis of, xiv, 285
— — prophylaxis of, xiv, 287
— — Public Health regulations for, xiv, 293
— — purulent forms of, v, 95
— — reflexes in, v, 85
— — sequelæ of, xiv, 293
— — serum disease and, xiv, 292
— — serum injection, v, 90, 96
— — serum treatment of, xiv, 288
— — symptoms of, xiv, 273
— — terminology of, xiv, 265
— — treatment of, xiv, 287
— — tuberculous, v, 96
— — types of, xiv, 276
— — typhoid fever differentiated from, xiv, 200
— — yeasts causing, v, 89
— causes of, iii, 243
— colon bacillus, cerebrospinal fluid in, xx, 112

Meningitis, infantile spinal, synonyms of, xiv, 224
— influenzal, cerebrospinal fluid in, xx, 110
— leukocyotsis in, xx, 43
— lobar pneumonia and, ix, 157, 159
— luetic, cerebrospinal fluid in, xx, 103
— meningococcus, cerebrospinal fluid in, xx, 100
— neurosyphilis clinically manifested by, xvii, 180
— paralysis of, hereditary syphilitic paralysis differentiated from, xvii, 240
— pneumococcus, cerebrospinal fluid in, xx, 100
— purulent, cerebrospinal fluid in, xx, 104
— — cerebrospinal leukocytosis in, v, 15
— staphylococcus, cerebrospinal fluid in, xx, 111
— streptococcus, cerebrospinal fluid in, xx, 111
— suppurative, organisms causing, xx, 100, 112
— syphilitic, cerebrospinal lymphocytosis in, v, 15
— — pathology of, xvii, 38
— — vomiting and, viii, 95
— tuberculous, v, 90
— — blood-sugar and, xx, 163
— — breathing irregular in, ix, 88
— — cerebrospinal fluid in, xx, 101
— — cerebrospinal lymphocytosis in, v, 15
— — cerebrospinal meningitis differentiated from, xiv, 280
— — clotting of cerebrospinal fluid in, v, 10
— — diagnosis of, xiv, 347
— — epidemic encephalitis differentiated from, xiv, 201
— — Froin's syndrome in, xx, 116
— — hip-joint tuberculosis and, vi, 82
— — miliary tuberculosis causing, xiv, 344, 345
— — poliomyelitis differentiated from, xiv, 243
— — prognosis of, vi, 71; xiv, 348
Meningitis, tuberculous, protein and relative sugar concentration of cerebrospinal fluid in, xx, 102
— — relative frequency of, ix, 231
— — symptoms of, xiv, 346
— — treatment of, xiv, 348
— — vomiting and, viii, 95
Meningocele, iii, 214, 217, 224; v, 50, 50
— anatomy of, vii, 47
— definition of, xv, 152
— hereditary syphilis and, i, 67
— prognosis of, vii, 48
— spina bifida and, xv, 210
Meningococcic meningitis, cerebrospinal fluid in, xx, 106
— diagnosis of, v, 90
— symptoms of, v, 89
Meningococcic serum, introduction of, v, 90
Meningococcus, acute infectious arthritis and, vi, 50
Meningo-encephalitis, choreiform movements in, xviii, 18
Meningomyelocele, anatomy of, vii, 47
— spina bifida and, xv, 210
Meningopolio-encephalitis, v, 102
Menstruation, education and, iv, 98
— lactation and recurrence of, xii, 190
— postural defects affecting, iv, 35
— vicarious, epistaxis and, ix, 19
Menstruation period, abortion and, i, 6, 45
— rest at, pregnancy and, i, 162
Mensuration, hip examination and, vi, 18
— orthopedic examination and, vi, 8
Mental ability, inheritance of, iv, 9
Mental conditions, pregnancy and, i, 30, 40, 160
— eclampsia and, i, 39
Mental defectives, classification of, v, 185
— congenital anomalies of structure, v, 187
— cortical injuries and, v, 194
— cretinism, v, 180
— delayed speech in, v, 195
— early degeneration, v, 180
— indefinite groups, v, 194
— mongolism, v, 180

Mental defectives, recognized types of, v, 187
Mental defects, types of, v, 208
— — epileptics, v, 211
— — intermediate, v, 209
— — moderate, v, 208
— — normal but with physical disability, v, 210
— — severe, v, 209
Mental deficiency, instrumental birth and, i, 111, 112
— neurosyphilis and, xvii, 199
Mental development in infancy, iv, 56
Mental growth, preventive pediatrics and, iv, 65
Mental hygiene, preventive pediatrics and, iv, 65
Mental measurements, iv, 78
Mental measurements in infancy, iv, 79
Mental measurements in preschool age, iv, 80
Mental reactions, deviations from normal due to, iv, 4
Mental tests, v, 154
Mentality, subnormal, heredity and, iv, 9
Menthol, acute rhinitis and, ix, 7
— pollen fevers and, ix, 119
Mercurial stomatitis, viii, 36
Mercuric oxid, impetigo contagiosa and, iii, 327
Mercuric salicylate, congenital syphilis and, ix, 15
Mercurochrome, accessory nasal sinus disease and, ix, 36
— acute follicular tonsillitis and, ix, 56
— acute infectious arthritis and, vi, 55
— acute pharyngitis and, ix, 41
— antiseptic use of, respiratory diseases and, ix, 262
— lobar pneumonia and, ix, 167
— peritonsillar abscess and, ix, 66
— sepsis neonatorum and, iii, 17
— Vincent's angina and, ix, 47
— wounds of soft parts and, xv, 8
Mercurochrome injections, puerperal infection and, i, 104
Mercury, accidental poisoning with, viii, 313
Mercury, administration of, iii, 56
— chlorid of, congenital syphilis treated with, i, 83
— congenital syphilis and, iii, 54
— dermatitis caused by, xvi, 42
— gonorrhea with, pregnant treated for, i, 62
— inunction, contraindicated in newborn, i, 73
— syphilis of bones and joints and, vi, 102; vii, 151
— syphilis with, pregnant treated for, i, 80, 84
— — dosage, i, 80
— toxemias contraindicating, i, 80
— treatment of syphilis with, xvii, 260
Mercury poisoning, anemia caused by, xx, 50
Mercury vapor quartz lamp, asthma and, ix, 116
—enlarged non-tuberculous bronchial glands and, ix, 211
— pathogenic microörganisms and, vii, 218
— results of exposure to, vii, 229
— rickets and, vii, 200; xiii, 117
— tetany and spasmophilia and, x, 253
— therapeutic use of, respiratory diseases and, ix, 260
— types of, vii, 228
— value of, vi, 75
Merrell-Soule Skimmed, composition of, xii, 32
Mesenteric glands, anatomy of, ix, 250
— tuberculosis of, diagnosis of, ix, 250; xiv, 343
— — relative frequency of, ix, 231
— — symptoms of, ix, 250
Mesentery, cysts of, treatment of, xv, 338
Mesocardia, iii, 105
Mesonephron, embryology of, xix, 1
Metabolism, abnormal development and growth and, dwarfism, xiii, 147
— — exogenous obesity, xiii, 137
— — fragilitas ossium, xiii, 164
— — infantilism, xiii, 145
— — Lorain infantilism, xiii, 145

Metabolism, abnormal development and growth and, malnutrition, xiii, 139
— — microcephalus, xiii, 164
— — mongolism, xiii, 153
— — obesity, xiii, 137
— — osteomalacia and osteogenesis imperfecta, xiii, 164
— — osteopsathyrosis, xiii, 164
— — progeria, xiii, 162
— — true infantilism, xiii, 145
— basal, definition of, xiii, 2
— — food consumed in, xii, 57
— — nephrosis and, xix, 81, 83
— calcium, x, 39
— carbohydrate, x, 33
— — disorders of, xx, 157
— — tolerance tests and, xx, 159
— carbonic acid and, xiii, 26
— chlorin, x, 41
— deficiency diseases and, acrodynia, xiii, 134
— — beriberi, xiii, 133
— — erythredema, xiii, 134
— — erythredema polyneuritis, xiii, 134
— — keratomalacia, xiii, 129
— — pellagra, xiii, 130
— — pink disease, xiii, 134
— — polyneuritis, xiii, 133
— — rickets, xiii, 112
— — scurvy, xiii, 119, 121
— — xerophthalmia, xiii, 129
— eczema and, xvi, 117
— fat, x, 30
— fetal, essence of, x, 49
— glands of internal secretion and, adrenal, xiii, 92
— — gonads, xiii, 95
— — interrelation of, xiii, 106
— — pancreas, xiii, 99
— — parathyroid, xiii, 71
— — pineal, xiii, 74
— — pituitary, xiii, 76
— — thymus, xiii, 87
— — thyroid, xiii, 44, 48
— inanition and, xiii, 25
— iron, x, 41
— magnesium, x, 40
— mineral salts, x, 38
— newborn, ii, 95
Metabolism, newborn, acidosis and, ii, 98
— — approximal basal during first 8 days, ii, 97
— — gaseous, ii, 95
— — protein, ii, 142
— — respiratory quotient, ii, 9
— — salt, ii, 95
— — weight gain and, ii, 42, 149
— normal, basal (standard) metabolism, xiii, 2
— — carbohydrate, xiii, 13
— — fat, xiii, 15
— — growth, xiii, 17
— — metabolism apparatus, xiii, 1
— — protein, xiii, 14
— — salts, xiii, 15
— pathological physiology and, xiii, 23
— phosphorus, x, 41
— protein, x, 36
— — immutability of, xii, 88
— rickets caused by faulty mineral, iv, 122
— sodium, x, 40
— standard, definition of, xiii, 2
— surgical aspects of certain diseases of, xv, 34
— water, importance of, xx, 132
Metabolism apparatus, Benedict cot-chamber, xiii, 1
— portable, xiii, 1
Metacarpus, postpartum fractures of, xv, 102
Metallic salts, hyperpigmentation due to ingestion of, xvi, 285
Metanephrogenic blastema, embryology of, xix, 1
Metanephron, embryology of, xix, 1
Metaphysis, fibrosis of, syphilitic osteochondritis and, i, 72
Metchnikoff, work on syphilis by, xvii, 15
Meteorism, cyanosis caused by, ii, 205
Methemoglobinemia, Winckel's disease and, iii, 2
Methods, therapeutic, respiratory diseases and, ix, 267
Methylene blue, acute infectious arthritis and, vi, 55
— Vincent's angina and, ix, 47
— wounds of soft parts and, xv, 8

Metric and avoirdupois weights, conversion table of, x, 292
Metritis, symptomatology of, i, 93
Meyer's solution, occult blood in stool and urine and, viii, 343
Microblepharon, iii, 359
Microcephalia, iii, 214
— anatomy of, vii, 53
— education impracticable for, v, 209
— identification of, xiii, 164
— mentality and, v, 188
Micrococcus, catarrhalis, meningitis caused by, xx, 106
Micrococcus of Unna, xvi, 136
Microcolon, iii, 151
— congenital, viii, 245
Microglossia, iii, 130; viii, 5
Micrognathia, iii, 131
Micromelia, iii, 283, 303
— definition of, vii, 57
Micropus, vii, 57
Microsporon furfur, xvi, 195
Micturition, frequency in newborn, ii, 100
— physiological considerations of, xix, 27
— prenatal, ii, 100
— psychic influences upon, xix, 30
Midbrain, disorders of, v, 218
Midges, xvi, 160
Midwifery practice, i, 151-154
— anesthetics in, i, 170
— birth injuries and, i, 127
— births in, percentage of, i, 152
— dangers of, i, 149
— elimination of, i, 154, 157
— maternal mortality and, i, 153
— nurses' training in, i, 159
— prenatal care and, i, 10, 154
— state supervision of, i, 152, 153, 154
Migratory pneumonia, ix, 149
Mikulicz' disease, glands affected by, viii, 55
Mild focal glomerulitis, clinical symptoms of, xx, 136
Mild hypothyroidism, definition of, xiii, 70
Miliaria, xvi, 277
— eczema differentiated from, xvi, 117
— premature showing presence of, ii, 164
Miliaria crystallina, xvi, 276
Miliaria rubra, iii, 349
Miliary tuberculosis, acute bronchitis differentiated from, ix, 104
— diagnosis of, ix, 237
— meningitis following, xiv, 344
— prognosis of, ix, 237
— symptoms of, ix, 236
— types of, xiv, 355
— typhoid fever and, viii, 191
— typhoid fever differentiated from, xiv, 200
Milium, iii, 350; xvi, 282
Milk, acidification of, iv, 54; x, 119
— acidified, xii, 36
— — buffer action and, xii, 20
— acidophilus, bacteriotherapy with, xx, 126
— additions to, xii, 129
— age of lactating animal and, xii, 10
— albumin, prematurity and, ii, 185
— alkalinized, buffer action and, xii, 20
— amount determined by weighing, ii, 133
— bacterial contamination of, xii, 14
— bacteriotherapy through medium of, xx, 123
— bottom, xii, 25
— breast, i, 139-148
— — bacteriology of, xx, 121
— — chemical examination of, xx, 120
— — diet affecting quality and quantity of, iv, 44; xii, 159, 166, 181
— — eczema and, iii, 330
— — fat in, x, 15
— — harelip limiting supply of, iii, 134
— — heredity and production of, xii, 166
— — inauguration of secretion of, iv, 44
— — maternal diet and, iv, 43
— — nervous system and, ii, 143
— — progress of lactation and increased yield of, xii, 168
— — protein in, x, 12
— — sepsis neonatorum and, iii, 16
— — tuberculosis and, iii, 63
— — worry affecting supply of, iv, 50

Milk, caloric value of, xii, 20
— casein, composition of, xii, 35
— cereal, preparation of, xii, 38
— chemical composition of, ii, 145; xii, 10, 19
— — office analysis of, xii, 20
— condensed, xii, 17
— — sweetened, xii, 34
— constipation caused by, xii, 126
— cow's, bacteriology of, xx, 121
— — composition of, xx, 121
— curdled, iv, 54
— diarrhea and, viii, 151
— diet in pregnancy and, i, 23, 165, 166
— — tuberculous cases and, i, 28
— direct methods of counting bacteria in, xx, 123
— diseases transmitted by, xii, 12, 13
— estimation of number of bacteria in, xx, 123
— evaporated, composition of, xii, 27
— ferments and, xii, 17, 37
— food value of, x, 27
— frozen, xii, 19
— — vomiting in infancy and, viii, 95
— gastric digestion of meat impaired by, xii, 130, 134
— gastro-intestinal infections and, iv, 147
— groups of substitutes for raw milk, xii, 23
— "held," xii, 17
— hydrogen ion content of, acidification and, xii, 21
— immunity through, iii, 8
— infant feeding with, i, 146
— — importance of, xii, 9
— infectious diseases conveyed by, xx, 122
— injections of, puerperal sepsis and, i, 103
— lactic-acid, calories in, x, 119
— later changes in, xii, 136
— malted, xii, 41
— maximum daily allowance of, xii, 137
— mixed, advantages of, xii, 13
— modifications of, weight gain and, ii, 44
Milk, normal child and, x, 123
— official grades of, xx, 124, 125
— pasteurization of, xx, 123
— — effects of, xii, 16, 19
— peptonization of, xii, 22
— P^H of, acidification and, xii, 21
— physiology of secretion of, xii, 155
— placental effect on secretion of, ii, 141
— preparations from, xii, 23
— — bottom milk, xii, 25
— — cream, xii, 24
— — cream and whey mixtures, xii, 26
— — dried milk, xii, 32
— — evaporated milk, xii, 27
— — skimmed milk, xii, 25
— — top milk, xii, 24
— proteins in, xii, 49
— — composition of, xii, 35
— regulations governing grades and designation of milk and cream for sale in New York City, xx, 124, 125
— scurvy and, vii, 205
— secretion in males and virgins, xii, 157
— secretion of, measures for increasing quantity of, iv, 46
— — nursing stimulating, ii, 142
— — primiparæ and multiparæ differing in amount of, ii, 143
— skimmed, xii, 25, 32
— source and preparation of, xii, 9, 14
— substitutes for, xii, 34
— — acidified milks, xii, 36
— — butter-flour mixtures (Czerny-Klein-Schmidt), xii, 39
— — cereal milk—concentrated foods, xii, 38
— — Eiweissmilch, xii, 35
— — fermented milks, xii, 37
— — malt preparations, xii, 41
— — protein, casein milk, xii, 35
— — Recolac, xii, 34
— — sugars and starches, xii, 40
— — sweetened condensed milk, xii, 34
— — synthetic milk (S. M. A. powder), xii, 40

Milk, sweetened condensed, composition of, xii, 34
— synthetic, preparation of, xii, 40
— top, xii, 24
— tuberculous infection and, xii, 12
— ultraviolet ray and, xii, 12
— vitamins in, xii, 10, 12, 17, 27
— witches', iii, 398
— woman's percentage composition of, xii, 161
Milk calcium, plasma calcium and, ii, 143
Milk fat, fat of newborn resembling, ii, 48
Milk leg, thrombophlebitis causing, i, 94
Milk-sickness, animals affected by, viii, 321
— etiology of, viii, 321
— incidence of, viii, 320
— symptoms of, viii, 322
— treatment of, viii, 322
Milk stools, ii, 91, 92
Milk substitutes, prematurity and, xii, 103
Milk sugar, ii, 146
— characteristics of, xii, 41
— relative value of, xii, 88
— source of, xii, 40
Milroy's disease, xvi, 309
Mind, development of, iv, 65
Mineral oil, infant care and, i, 172
— laxative use of, respiratory diseases and, ix, 263
Mineral salts, digestion of, x, 38
— foods containing, x, 28
— food value of, x, 17
— metabolic importance of, x, 18
— metabolism of, x, 38; xiii, 16
— milk and, x, 27
— sunshine and, x, 25
Miscarriage, after-care, i, 28
— artificial, i, 6, 18, 29, 42
— cardiac cases and, i, 33
— criminal, i, 6, 45
— death from, i, 47
— fibromyomata and, i, 42
— frequency of, iv, 106
— gonorrhea and, i, 61
— ovariotomy and, i, 41
— patient's history of, i, 17
Miscarriage, prenatal care and, i, 2, 7, 12, 44-48
— prevention of, i, 162
— retrodisplacements and, i, 20
— septic uterus following treatment of, i, 90
— syphilis and, i, 77, 78
— — pregnant mothers treated for, i, 82
— tubal infections and, i, 6
— tuberculosis and, i, 29
— tumors of uterus and, i, 42
— uterine myomata and, i, 42
Misplacements, uterine, prevention of, i, 160, 161
Mites, xvi, 158, 168
Mitral insufficiency, diagnosis of, xviii, 196
— pathological physiology of, xviii, 44
— physical signs of, xviii, 114
— x-ray signs of, xviii, 158
Mitral stenosis, diagnosis of, xviii, 195
— pathological physiology of, xviii, 44
— physical signs of, xviii, 116
— pregnancy and, i, 30, 31, 32
Mitral valves, pathological physiology of, xviii, 44
Mittens, ii, 129
Mixed glomerulotubular nephritis, acute, blood chemistry of, xx, 143
— — clinical features of, xx, 143
Mixed milk, advantages of, xii, 13
Modern social life, nursing mothers, and, i, 139
— pregnancy and, i, 24
— prenatal care and, i, 1
Moist heat, counterirritant use of, respiratory diseases and, ix, 257
Moist râles, significance of, ix, 98
Molars, syphilitic hypoplasia of, xvii, 222
Molding, neurological factors of, v, 22
— presentation affecting degree of, ii, 24
— size affected by, ii, 10
Moles, pigmented, iii, 333

Molluscum contagiosum, course of, xvi, 326
— diagnosis of, xvi, 327
— etiology of, xvi, 326
— pathology of, xvi, 326
— prognosis of, xvi, 327
— symptoms of, xvi, 325
— treatment of, xvi, 327
Mongolian blue spot, iii, 345
Mongolian idiocy, Little's disease differentiated from, vi, 240
Mongolian pigment spots, iii, 345; xvi, 284
Mongolism, brain development in, x, 72
— congenital heart disease and, xviii, 136
— cretinism differentiated from, xiii, 159
— diagnosis of, xiii, 159
— education impracticable for, v, 209
— etiology of, iii, 251; xiii, 153
— heart disease frequent in, iii, 103
— hypothyroidism differentiated from, xiii, 52
— incidence of, xiii, 153
— macroglossia in, iii, 130
— mentality and, v, 189
— metabolism and, xiii, 159
— morbid anatomy of, xiii, 153
— prognosis of, xiii, 161
— symptoms of, xiii, 155
— treatment of, v, 191; xiii, 161
Monilethrix, etiology of, xvi, 255
— symptoms of, xvi, 254
— treatment of, xvi, 255
Monilia albicans, xvi, 343
Monkey trot exercise, misplacements prevented by, i, 161
— retrodisplacements, illus., i, 20
Monobrachia, cause of, vii, 55
Mononucleosis, acute infections, lymphatic leukemia differentiated from, xi, 141
— infectious, blood changes in, xx, 55
— — blood-count in, xi, 47
— — synonyms of, xiv, 314
Monopus, vii, 57
Monstrosities, hereditary syphilis and, i, 67
Montgomery's glands, ii, 139
Monthly weight gain in infancy, iv, 24
Moon's tooth, xvii, 223
Morality, factors governing, v, 155
Moral sense, feeble-mindedness and lack of, iv, 10
Morbidity, childhood, iv, 105, 120
— infant, iv, 105, 120
— motherhood and, i, 5
— prenatal care and, i, 16
— preschool age, iv, 120
— puerperal infections and, i, 90
— school age, iv, 121
— vaginal examinations and, i, 96
Morbilli, synonyms of, xiv, 34
Morbus cæruleus, iii, 113
Morbus maculosus, viii, 273
— Werlhof's, first description of, xi, 3
— — symptoms of, xvi, 69
Morbus virgineus, xi, 3
Morgagni, syphilis described by, xvii, 8
Moron, definition of, v, 185
Morphea, xvi, 304
— vitiligo differentiated from, xvi, 293
Morphin, abruptio placentæ and, i, 55, 56
— acute decompensation and, i, 32
— asphyxia neonatorum and, ii, 191
— cardiac cases at labor and, i, 33
— convulsions controlled by, i, 38; iii, 248
— cyanosis caused by uses of, ii, 205
— dermatitis caused by, xvi, 48, 52
— labor anesthesia and, tuberculosis and, i, 29
— placenta prævia and, i, 58
— placental separation and, i, 55
— shock after labor and, i, 134
— tetanus neonatorum and, iii, 34
— use during labor, ii, 123
Morphinism, size of child affected by, ii, 14
Mortality, age of infants and, iv, 110
— antenatal, iv, 106
— childhood, iv, 105, 118
— infant, iv, 105
— — age of mother and, iv, 116
— — age rates, i, 7, 8
— — breast feeding and, i, 140
— — causes of, i, 7, 14, 149

Mortality, infant, decline in rate of, iv, 108
— — diet and, iv, 117
— — early, causes of, i, 6, 7
— — enlarged thymus and, i, 138
— — factors influencing rate of, iv, 12, 114
— — factory day nurseries and, i, 156
— — falx and tentorium rupture causing, i, 117
— — general discussion of, iv, 107
— — hemorrhages of central nervous system causing, i, 118, 119, 120
— — housing relationships affecting, iv, 115
— — ignorance and poverty affecting, iv, 114
— — illegitimacy and, iv, 116
— — maternal syphilis and, iv, 107
— — measles and, iv, 136
— — nativity of mother and, iv, 116
— — prenatal care and, clinical reports of, i, 10-13
— — race and, iv, 116
— — rate in England and Wales, iv, 108
— — respiratory infections and, iv, 112
— — rural and urban rates for, iv, 113
— — seasonal incidence of, i, 4; iv, 112
— — sepsis causing, i, 98
— — specific causes of, iv, 111
— — spinal injuries causing, i, 121
— — syphilis causing, i, 7, 64, 65, 77, 84
— maternal, acute yellow atrophy causing, syphilis and, i, 80
— — anesthesia causing, acidosis and, i, 130, 131
— — asepsis and, i, 86
— — cesarean section and, i, 92
— — conception, frequency of, i, 6
— — eclampsia and, i, 39, 92
— — midwives' responsibility for, i, 153
— — milk leg and, i, 94
— — miscarriage and, i, 47
— — obstetrical technic and, i, 150
— — placenta and, manual removal of, sepsis in, i, 97
Mortality, maternal, prenatal care and rate of, i, 10-13, 90
— — puerperal sepsis and, i, 4, 86, 90, 101, 104
— — rates, i, 2-5
— — sepsis and rate of, i, 98
— — shock at labor and, i, 130, 131
— — thrombophlebitis and, i, 104
— newborn, fourteen days and under, ii, 4
— — measures for meeting the problem of, ii, 8
— — prematurity and, ii, 3, 176
— — statistical data, ii, 3
— postnatal familial syphilis and, xvii, 103
— preschool age, iv, 118, 119
— school age, iv, 105
Mortality rate, causes of infant death and, iv, 111
— infant, iv, 108, 109
Morviglione, synonyms of, xiv, 69
Moser serum, scarlet fever and, xiv, 30
Mosquitoes, iii, 348; xvi, 160
— malarial, characteristics of, xiv, 210
Mother, advice to, ii, 135
— pregnant, clothes for, i, 162
— prenatal care of, i, 1, 16-62
— syphilitic infection through, fetus and, i, 64, 66
— Wassermann reaction in, i, 78
Mother's helper, prenatal care and, i, 155
Motor disturbances, brain tumors causing, v, 118
Motor nerve injuries, v, 214
Motoring, pregnancy and, i, 24, 168
— abortion and, i, 45
Moulding, head, birth injuries due to, i, 112
Mouth, characteristics at birth, viii, 1
— delayed speech due to anomalies of, v, 196
— diseases of, abscess of gums, viii, 13
— — cancrum oris, viii, 30
— — catarrhal stomatitis, viii, 22
— — follicular stomatitis, viii, 24
— — frenal ulcer, viii, 12
— — gangrenous stomatitis, viii, 30

Mouth, diseases of, geographic tongue, viii, 15
— — gingivitis, viii, 13
— — glossitis, viii, 16
— — herpes of lip, viii, 12
— — herpetic stomatitis, viii, 24
— — hypertrophy of gums, viii, 14
— — maculofibrinous stomatitis, viii, 24
— — mercurial stomatitis, viii, 36
— — necrosis of jaw, viii, 16
— — noma, viii, 30
— — periostitis of gums, viii, 13
— — Riga's disease, viii, 12
— — sarcoma of jaw, viii, 17
— — scurvy of gums, viii, 14
— — stomatitis, viii, 19
— — syphilis, viii, 17
— — thrush, viii, 19
— — tumor of, viii, 16
— — ulceration of hard palate, viii, 35
— — ulcerative stomatitis, viii, 26
— herpetic inflammation of, xvi, 342
— infection occurring at birth, ii, 117
— nflammation of, viii, 19
— malformations of structure of, viii,
— — cleft-palate and harelip, viii, 6
— — cyst, viii, 6
— — tongue-swallowing and, viii, 4
— — tongue-tie, viii, 2
— — tumors and deformities of tongue, viii, 4
— microörganisms at birth in, viii, 2
— newborn, anatomy of, iii, 124
— — diseases of, iii, 188
— — hemorrhage of, iii, 182
— — sepsis neonatorum by way of, iii, 12
— physiology of, ii, 82
— rhagades at, syphilitic infants and, i, 75
— salivary secretion, ii, 84
— secretions of, examination of, xx, 91
— sucking mechanism of, viii, 2
— surgery of, acute retropharyngeal abscess, xv, 178
— — cleft-palate, xv, 166
— — congenital cleft lip, xv, 166
— — congenital tongue-tie, xv, 174
Mouth, surgery of, harelip, xv, 166
— — macroglossia, xv, 175
— — macrostomia, xv, 173
— — peritonsillar abscess, xv, 180
— — quinsy, xv, 180
— — ranula, xv, 176
— — ulcers of frenum, xv, 175
— — Vincent's angina, xv, 180
— syphilis of, viii, 17
— tuberculosis ulcerosa about, xvi, 232
Mouth-breathing, dangers of, ix, 70
— malnutrition and, iv, 157
— pollen fevers and, ix, 118
— tonsillectomy and, ix, 60
Movements, fetal, cessation of, death in utero and, i, 50
Mucin, ii, 92; xx, 6
Mucous membranes, diseases of, black tongue, xvi, 340
— — Fordyce's disease, xvi, 340
— — furrowed tongue, xvi, 341
— — general considerations of, xvi, 338
— — herpetic stomatitis, xvi, 342
— — lingua geographica, xvi, 338
— — perlèche, xvi, 343
— — thrush, xvi, 343
— gummata of, hereditary syphilis and, xvii, 249
— nasal, syphilitic infants and, i, 75
— syphilitic lesions of, clinical incidence of, xvii, 116, 126
Mucous patches, acquired syphilis and, xvii, 240
— incidence of, xvii, 129
Mucous râles, significance of, ix, 98
Mucus, aspiration of, cyanosis caused by, ii, 205
— tecal, significance of, xx, 72
— intestinal indigestion stools showing, xii, 120
— newborn and, i, 136
Mulberry molar, syphilitic stigmata causing, xvii, 223
Müllerian ducts, development of, xix, 4, 6
Multiparæ, abruptio placentæ in, i, 52
— induction of labor in, i, 108, 109
Multiple abnormalities, prenatal factors in, v, 141
Multiple abscesses of infants, xvi, 219

Multiple benign cystic epithelioma, diagnosis, symptoms and treatment of, xvi, 27
Multiple cartilaginous exostoses, clinical signs and symptoms of, vii, 21
— complications of, vii, 26
— diagnosis of, vii, 25
— etiology of, vii, 20
— general considerations of, xv, 121
— localization of lesions of, vii, 22
— microscopic anatomy of, vii, 24
— pathology of, vii, 23
— symptoms of, vii, 21
— treatment of, vii, 26
— x-ray appearance of, vii, 25
Multiple disseminated lupus, measles followed by, xvi, 226
Multiple enchondromata, diagnosis of, vii, 28
— etiology of, vii, 27
— general considerations of, vi, 191
— pathology of, vii, 28
— treatment of, vii, 28
Multiple neuritis, endemic, x, 264
— gait in, v, 13
Multiple osteochondroma, vi, 192
Multiple pigmented sarcoma, diagnosis of, xvi, 334
— etiology of, xvi, 334
— incidence of, xvi, 334
— treatment of, xvi, 335
Multiple pregnancy, prematurity caused by, ii, 163
Multiple pulmonic thrombi, arsphenamin injections causing, xvii, 271
Multiple selerosis, abdominal reflex and, v, 12
— general nature of, v, 220
Mumps, bacteriology of, xiv, 143
— complications of, xiv, 147
— definition of, xiv, 141
— diagnosis of, xiv, 149
— etiology of, xiv, 141
— glands affected by, viii, 56
— glandular fever differentiated from, xiv, 318
— history of, xiv, 141
— incubation period of, xiv, 144
— leukocytosis in, xx, 47
— medicinal treatment of, xiv, 151
Mumps, newborn and, iii, 28
— pathology of, xiv, 144
— prevention of, iv, 141
— preventive treatment of, xiv, 150
— prognosis of, xiv, 150
— Public Health regulations for, xiv, 151
— recurrence of, xiv, 147
— rheumatic infections and, xviii, 78
— susceptibility to, iv, 129
— symptoms of, xiv, 144
— synonyms of, xiv, 141
— transmission of, xiv, 142
— treatment of, xiv, 150
— underfunction of female gonads caused by, xiii, 98
Municipal nurses, maternity protection and, i, 155
Munro's abscesses, psoriasis and, xvi, 128
Murmurs, heart, xviii, 97
— — Austin Flint, xviii, 195
— — diastolic, i, 31
— — functional types of, i, 196
— — interpretation of, iii, 115
— — presystolic, i, 31
— — systolic, i, 30
Murphy drip, premature infant feeding and, ii, 182
Muscle, affections of, orthopedic, vi, 49, 210
— atrophy and paralysis of, nerve center injury causing, vii, 240
— bladder, xix, 27
— control of, development period of, x, 74
— development of, x, 63
— diseases of, acute poliomyelitis, vii, 240
— — acute torticollis, vii, 237
— — atrophies and dystrophies, vii, 251
— — brachial plexus birth paralysis, vii, 256
— — cerebral spastic paralysis, vii, 246
— — dermatomyositis, vii, 234
— — dystrophies, vii, 253
— — Erb's palsy, vii, 256
— — facioscapulohumeral muscular dystrophy (Landouzy and Déjerine type), vii, 255

Muscle, diseases of, flaccid paralysis, vii, 240
— — Heine-Medin disease, vii, 240
— — hemorrhagic polymyositis, vii, 234
— — hereditary muscular atrophy, Leyden-Möbius, vii, 255
— — infantile paralysis, vii, 240
— — infantile progressive muscular atrophy (Werdnig-Hoffmann type), vii, 252
— — ischemic muscular atrophy, vii, 239
— — ischemic myositis, vii, 239
— — myositis, vii, 234
— — myositis fibrosa, vii, 234
— — obstetrical paralysis, vii, 256
— — paralysis from birth injuries, vii, 247
— — parasitic myositis, vii, 237
— — postparalytic atrophy from peripheral nerve injury, vii, 256
— — primary myositis, vii, 234
— — progressive muscular atrophy (Hand type), vii, 251
— — progressive neural muscular atrophy (Charot-Marie-Tooth), vii, 252
— — simple hereditary atrophic muscular dystrophy, vii, 255
— — simple myositis, vii, 234
— — spastic paralysis, vii, 246
— — toxic myositis, vii, 237
— — traumatic myositis, vii, 239
— — trichiniasis, vii, 237
— — trichinosis, vii, 237
— — Volkmann's contracture, vii, 239
— — Volkmann's paralysis, vii, 239
— — wry-neck, vii, 237
— heart, pregnancy and, i, 31
— hypotonia and mongolism, v, 189
— inanition affecting, x, 216
— inflammations of, vi, 211; vii, 234
— malnutrition and, x, 178
— muscular atrophies and dystrophies, vii, 251
— newborn, characteristics of, ii, 48
— — disease of, iii, 312
— — hematoma of, iii, 312
— — malformations of, iii, 310
— rickets affecting, x, 239
Muscle, rigidity of, pregnancy and, i, 18
— rupture of, vi, 210
Muscle synergia, ataxia showing absence of, v, 12
Muscle tone, control of, v, 1
— malnutrition and, iv, 150, 161
— normal child and, x, 109
— spasticity and, v, 151
— sympathetic system and, v, 2
Muscle training, fundamental ideas back of, v, 29
Muscular activity, metabolism and, xiii, 4
Muscular atrophy, hereditary, Lyden-Möbus', vii, 255
— infantile progressive (Werdnig-Hoffmann type), vii, 252
— ischemic, vii, 239
— juvenile type of, vii, 256
— neural progressive, v, 215
— progressive, clinical course of, vi, 246
— — diagnosis of, vi, 247
— — etiology of, vi, 246
— — general considerations of, iii, 250
— — hand type of, vii, 251
— — muscular dystrophy differentiated from, vi, 247
— — pathology of, vi, 246
— — symptoms of, vi, 246
— — treatment of, vi, 247
— progressive neural, of Charcot-Marie-Tooth, vii, 252
— sex-linked heredity and, iv, 8
— Werdnig-Hoffmann's, iii, 250
Muscular dystrophy, clinical forms of, vi, 248
— diagnosis of, vi, 249
— etiology of, vi, 248
— facioscapulohumeral (Landouzy and Déjerine type), vii, 255
— general considerations of, vii, 253
— pathology of, vi, 248
— prognosis of, vi, 249
— progressive muscular atrophy differentiated from, vi, 247, 249
— simple hereditary atrophic, vii, 255
— symptoms of, vi, 248
— treatment of, vi, 249

Muscular movements, inauguration of, ii, 111
Musculocutaneous reflexes, newborn, ii, 113
Musical functional murmurs, xviii, 197
Mustard, acute bronchitis and, ix, 105
— asthma and, ix, 115
— bronchopneumonia and, ix, 135
— counterirritant use of, respiratory diseases and, ix, 258,
Myasthenia gravis, iii, 312
Myelocele, general considerations of, iii, 217
— spina bifida and, xv, 211
Myelocystocele, iii, 217
Myelocytes formation of, xi, 19
Myelodysplasia, enuresis associated with, xix, 48
Myelogenous leukemia, acute form of, blood changes in, xx, 58
— — blood-count of, xi, 152, 154
— — case history of, xi, 150
— — diagnosis of, xi, 155
— — symptoms of, xi, 153
— — treatment of, xi, 155
— chronic form of, blood-count of, xi, 158
— — case history of, xi, 156
— — symptoms of, xi, 159
— — treatment of, xi, 160
Myeloma, chloroma differentiated from, xi, 172
— endothelial, vii, 162
— general considerations of, vi, 200
— leukemia and, xi, 130
Myelitis, spinal neurosyphilis and, xvii, 207
Myocarditis, diphtheria causing, xiv, 165, 173
— lobar pneumonia causing, ix, 159
— measles complicated by, xiv, 46
— rheumatic pathology of, xviii, 21
— — x-ray signs of, xviii, 160
Myocardium, pathological physiology of, xviii, 47
Myoma, uterine, pregnancy and, illus., i, 44, 45, 46, 51
— — hemorrhage and, fatal, i, 11
— — prenatal care and, i, 42
Myomectomy during pregnancy, i, 42
Myopathies, general considerations of, v, 63
Myopia, albinism and, iii, 359
Myosin, amount present at birth, ii, 48, 111
Myositis, general considerations of, iii, 312
— ischemic, vii, 239
— — diagnosis of, vi, 212
— — etiology of, vi, 211
— — pathology of, vi, 212
— — prognosis of, vi, 213
— — symptoms of, vi, 212
— — treatment of, vi, 213
— parasitic, vii, 237
— primary, vii, 234
— simple, vii, 234
— toxic, vii, 237
— Volkmann's traumatic, vii, 239
Myositis fibrosa, vii, 234
Myositis ossificans, etiology of, vi, 213
— general considerations of, iii, 312; vii, 235
— pathology of, vi, 214
— sprain of elbow causing, vi, 122
— treatment of, vi, 215
— types of, vi, 213
Myositis ossificans traumatica, clinical features of, xv, 124
Myotonia congenita, general considerations of, iii, 312
Myxedema, congenital, clinical features of, xv, 120
— — general considerations of, iii, 380
— — treatment of, xv, 121
— dwarfism and, x, 138
— hypothyroidism differentiated from, xiii, 66
— infantilism and, x, 140
— symptoms of, xiii, 69

Nails, appearance at birth, ii, 13
— Beau's lines of, xvi, 267
— congenital malformations of, xvi, 264
— constitutional diseases affecting, xvi, 267
— diseases of, xvi, 263
— — general diagnosis of, xvi, 270
— — koilonychia, xvi, 269

Nails, diseases of, leukonychia, xvi, 269
— — onychauxis, xvi, 264
— — onychorrhexis, xvi, 269
— — paronychia, xvi, 270
— — psoriasis, xvi, 268
— — ringworm of, xvi, 179
— — treatment of, xvi, 271
— — whitlow, xvi, 270
— Hippocratic, xvi, 267
— localized dermatoses affecting, xvi, 268
— miscellaneous affections of, xvi, 269
— psoriasis of, symptoms of, xvi, 125
— ringworm of, xvi, 179
— — diagnosis of, xvi, 183
— — treatment of, xvi, 188
— spoon, xvi, 269
— traumatic affections of, xvi, 266
— white, xvi, 269
Nap, daily, nursing mothers and, i, 142
Naphthalin, Winckel's disease and, iii, 2
Napkin dermatitis, hereditary syphilitic lesions differentiated from, xvii, 244
Napkin erythema, diagnosis of, xvi, 35
— etiology of, xvi, 35
— symptoms of, xvi, 35
— treatment of, xvi, 36
Narrowing, esophageal, congenital, viii, 74
— meatal, complications of, xix, 215
Nasal accessory sinuses, diseases of, chronic tonsillitis and, ix, 59
— — complications of, ix, 34
— — diagnosis of, ix, 32
— — etiology of, ix, 26
— — incidence of, ix, 31
— — pathology of, ix, 27
— — predisposing factors in, ix, 27
— — related affections, ix, 30
— — symptoms of, ix, 27
— — treatment of, ix, 35
— — x-ray technic in, ix, 31
— histology of, ix, 26
Nasal affections, accessory sinus disease, ix, 21
— acute rhinitis, ix, 1
— atrophic rhinitis, ix, 13
— chronic rhinitis, ix, 10
Nasal affections, diphtheritic rhinitis, ix, 16
— epistaxis, ix, 17
— hemorrhage, ix, 17
— hypertrophic rhinitis, ix, 12
— nosebleed, ix, 17
— syphilitic rhinitis, ix, 15
— traumatic rhinitis, ix, 17
— tuberculous rhinitis, ix, 16
Nasal breathing, malnutrition from obstruction of, iv, 157, 160
Nasal catarrh, chronic, ix, 9
Nasal diphtheria, symptoms of, xiv, 163
Nasal hemorrhage, ix, 17
Nasal mucous membranes, syphilitic infants and, i, 75
Nasal polypi, epistaxis from, ix, 18
Nasal scabs, treatment of, ix, 14
Nasal secretions, examination of, xx, 91
Nasal sinuses, accessory, rheumatic infection and, xviii, 69
Nasopharyngitis, chronic, ix, 9
Nasopharynx, anatomy and physiology of, ix, 38
Nasse's law, xi, 3
Natural immunity, xiv, 6
Nausea, bromids for control of, respiratory diseases and, ix, 264
— pregnancy and, i, 25, 26, 168
Navel, amniotic, iii, 400
— cutis, iii, 400
Navicular bone, tarsal, osteochondritis of, vii, 77
Nearsightedness, development of, iv, 156
Necator americanus, intestinal infestation with, viii, 303
— morphology and identification of, xvi, 171; xx, 80
Neck, acute cervical adenitis, xv, 189
— acute suppurative sialo-adenitis, xv, 188
— cellulitis of, xv, 191
— cervical auricles, xv, 188
— cervical ribs, xv, 188
— cystic hygroma, xv, 197
— cysts of, xv, 183
— dermoid cysts of, xv, 184
— fistula of, xv, 183

Neck, goiter, xv, 200
— lateral cysts and fistulæ of, xv, 183
— orthopedic apparatus for, vi, 39
— proportions at birth, ii, 27
— rigidity of neurosyphilis and, xvii, 186
— surgery of, branchial cysts and fistulæ, xv, 183
— — thyroglossal cysts and fistulæ, xv, 185
— thymus surgery, xv, 203
— thyroid surgery, xv, 200
— tuberculosis of cervical glands, xv, 192
— wry, orthopedic management of, vi, 292
Necrosis, maxillary, viii, 16
— symptoms of, pregnancy and, i, 44
Necrotic tonsillitis, Vincent's, viii, 41
Negri bodies, rabies and, xiv, 325, 327; xv, 13
Negro, neurosyphilis in, incidence of, xvii, 175
Neighborhood guilds, prenatal care and, i, 156
Neisser, complement deviation described by, xvii, 15
Nélaton's line, hip examination and, vi, 18; vii, 59
Neo-arsphenamin, congenital syphilis and, iii, 54
— syphilis of bones and joints and, vi, 102; vii, 151
— technic of administration to infants, iii, 55
— treatment of syphilis with, i, 82; xvii, 263
— ulcerative stomatitis and, viii, 30
Neonatal deaths, i, 2
— causes of, i, 8
— — syphilis, i, 63, 79
— — traumatism at labor, i, 111
— prenatal care and, i, 12
— spinal injuries and, i, 121
Neonatal management, i, 136-149
— hemorrhagic tendencies and, i, 138
— infant care in, i, 136
— mastitis and, i, 147
— nursing and, i, 139
Neonatal period, anatomy during, x, 51
Neonatal period, length of, x, 50
Neoplasms, bone, benign, vi, 192
— — chondroma, vi, 193
— — endothelioma, vi, 199
— — malignant, vi, 196
— — myeloma, vi, 200
— — osteochondroma, vi, 192
— — periosteal sarcoma, vi, 197
— — recurrent, vi, 196
— joint, types of, vi, 125
— skin, xvi, 315
— — malignant, xvi, 331
Neosalvarsan, treatment of congenitally syphilitic infants and, i, 83
Neosilvol, acute rhinitis and, ix, 7
— antiseptic use of, respiratory diseases and, ix, 262
Nephrectomy, function following, xix, 26
Nephritis, abruptio placentæ and, i, 52
— accessory nasal sinus disease and, ix, 34
— acute, acidosis accompanying, xx, 173
— — bacteriology of, xx, 145
— — breast feeding presented by, ii, 150
— — chickenpox causing, xiv, 74
— — newborn seldom afflicted with, ii, 7
— — prematurity caused by, ii, 163
— — prognosis of, xx, 146
— — recognized groups of, xx, 135
— — scarlet fever complicated by, xiv, 20
— — treatment of, xiv, 30
— — scurvy differentiated from, vii, 212
— — size affected by maternal affliction with, ii, 14
— acute bronchitis and, ix, 102
— acute follicular tonsillitis causing, ix, 54
— acute glomerular (hemorrhagic), acidosis in, xx, 173
— — blood chemistry in, xx, 138
— — clinical symptoms of, xx, 136
— — kidney function in, xx, 138
— acute luetic, blood chemistry in, xx, 147

Nephritis, acute mixed glomerulotubular, blood chemistry of, xx, 143
— — clinical features of, xx, 143
— acute purulent. *See* Pyuria.
— acute tubular (parenchymatous) blood chemistry in, xx, 142
— — clinical features of, xx, 139
— anemia with, xx, 50
— arteriosclerotic, blood chemistry in, xx, 153
— — clinical features of, xx, 152
— blood chemistry in, xx, 135
— bronchopneumonia and, ix, 130
— chronic, acidosis in, xx, 173
— — classification of, xx, 148
— — epistaxis and, ix, 18
— — pregnancy and, i, 22
— chronic diffuse, chyluria in, xix, 67
— chronic glomerular, blood chemistry in, xx, 150
— — clinical features of, xx, 148
— chronic interstitial, blood chemistry in, xx, 153
— — clinical features of, xx, 152
— congenital, iii, 273
— convulsions and, v, 136
— degenerative, blood chemistry in, xx, 151
— — clinical features of, xx, 150
— — conditions associated with, xx, 152
— eczema and, xvi, 117
— experimental, physiological findings from, xix, 24
— fetal death and, i, 48
— heart complications in, xviii, 193
— heliotherapy contra-indicated in, ix, 260
— hemorrhagic, forms of, xix, 102, 106, 107
— — general considerations of, xix, 101
— hyperglycemia and, xiii, 14
— interstitial, congenital syphilis causing, iii, 59
— maternal deaths due to, i, 5
— nursing and, iv, 48
— outline for work-up of cases of, xx, 156
— parenchymatous, xix, 78. *See also* Nephrosis
Nephritis, pleurisy following, ix, 193
— rheumatic carditis and, xviii, 89
— syphilitic, incidence of, xvii, 140
— toxemia and, i, 37
— tubular, xix. See also Nephrosis
Nephrodystrophy. *See* Nephrosis
Nephropathy, chronic diffuse, renal lesions in, xix, 125
— — vascular lesions in, xix, 127
— diagnostic features and therapeutic indications in, xix, 118, 119
— infantile, incidence of, xix, 129
Nephrosclerosis, blood chemistry in, xx, 153
— clinical features of, xx, 152
Nephrosis, blood changes in, xix, 84
— blood-count in, xi, 70, 73
— clinical features of, xx, 151
— definition of the term, xix, 78
— etiology of, xix, 79
— histology of, xix, 78
— incidence of, xix, 80, 81
— prognosis of, xix, 88, 100
— symptoms of, xix, 78
— treatment of, xix, 90
Nerves, cell regeneration in, v, 25, 35
— mammary gland supply of, ii, 141
— micturition controlled by, xix, 29
— peripheral, injuries to, vi, 250
— — postparalytic atrophy from injury to, vii, 256
— renal, function of, xix, 22
— stigmata of, latent syphilis and, xvii, 226
Nervous disorders, basal ganglia and, v, 218
— bodily welfare and, v, 174
— cerebellar, v, 217
— cerebral cortex and, v, 218
— convalescence and, v, 174
— conventional syndromes, v, 212
— danger of *laissez-faire* attitude in study of, v, 162
— endocrinology and, v, 171
— general, v, 219
— hysteria, v, 170
— medullary, v, 216
— mental defectives, v, 185
— mental tests in, v, 154
— methods of approach in study of, v, 153, 158

Nervous disorders, midbrain lesions and, v, 218
— optic thalamus and, v, 218
— peripheral, v, 215
— pineal body and, v, 218
— pituitary body and, v, 218
— pons, nuclear, v, 217
— speech defects, v, 195
Nervous system, affections of, anterior poliomyelitis, vi, 218
— — birth paralysis, vi, 243
— — encephalitis, v, 101
— — epidemic encephalitis, v, 97
— — Friedreich's ataxia, vi, 250
— — hereditary ataxia, vi, 250
— — hydrocephalus, v, 111
— — hysterical paralysis, vi, 254
— — infantile paralysis, v, 102
— — Little's disease, vi, 237
— — meningitis, v, 84
— — muscular dystrophy, vi, 248
— — obstetrical paralysis, vi, 243
— — orthopedic, vi, 49
— — orthopedic management of, vi, 218, 237
— — pachymeningitis hæmorrhagica interna, v, 84
— — peripheral nerve injuries, vi, 250
— — progressive muscular atrophy, vi, 246
— — spastic cerebral paralysis, vi, 237
— — tuberculosis, v, 83; xiv, 345
— — tuberculous meningitis, v, 96
— anatomy and physiology of, v, 1, 5
— birth injuries affecting, v, 20
— brain tumors, v, 117
— cerebrospinal fluid interpretation, v. 13
— cerebrospinal meningitis, v, 84
— chronic encephalitis, v, 100
— congenital anomalies, v, 50
— congenital syphilis and, iii, 59; v, 82
— convulsions, v, 128
— delivery affecting, v, 20
— diphtheria affecting, v, 80
— familial conditions and, v, 60
— hemorrhage in, i, 118, 119, 120
— hereditary conditions and, v, 60
— infection affecting, v, 76
— injuries at birth and, i, 124, 125
Nervous system, intracranial injuries and, v, 42
— localization of lesions by reflexes, v, 6
— lumbar puncture technic, v, 86
— milk secretion affected by, ii, 143
— mortality from birth injury of, v, 24
— motor cell location, v, 6
— newborn, iii, 212
— — convulsions due to trauma, ii, 112; v, 129
— — corneal reflex, ii, 113
— — electrical excitability at birth, ii, 112
— — icterus neonatorum and, ii, 219
— — malformations of, iii, 213
— — musculocutaneous reflexes, ii, 113
— — oculocardiac reflex, ii, 113
— — peculiarities in, ii, 172
— — pharyngeal reflex, ii, 113
— — prematurity and, ii, 168
— — pupillary reflexes, ii, 113
— — reflexes at birth, ii, 113
— — regeneration of tissues of, v, 129
— — resistance to stimuli, v, 129
— — tendon reflexes, ii, 113
— ophthalmoscopic examination, v, 17, 118
— peripheral nerve injuries, v, 26
— physiology of, v, 1
— predilection for spirochete to locate in, xvii, 182
— prenatal care and, i, 39-41
— regeneration of cells of, v, 25, 35
— routine examination of, v, 8
— secondary infections of, v, 80
— skull defects affecting, v, 50
— spinal cord injuries, v, 34
— spinal cord tumors, v, 121
— syphilis affecting, v, 81
— — pathological evidence of, xvii, 31, 37
— tension and, i, 24
— — breast milk and, i, 144
— tuberculosis of, v, 83; xiv, 345
— tumors of brain, v, 117
— tumors of spinal cord, v, 121
— "upper motor neuron," v, 7
— whooping-cough sequelæ in, v, 80

Nestlé's Food, xii, 42
Nettle rash, character of, xvi, 43
— course of, xvi, 74
— diagnosis of, xvi, 75
— etiology of, xvi, 74
— pathology of, xvi, 74
— prognosis of, xvi, 76
— symptoms of, xvi, 73
— treatment of, xvi, 76
Neural muscular atrophy, progressive (Charcot-Marie-Tooth), v, 215; vii, 252
Neuralgia, accessory nasal sinus disease and, ix, 34
— gastric, pregnancy and, i, 168
— toxemias of pregnancy and, i, 37
Neuritis, endemic multiple, x, 264
— optic, congenital syphilis causing, iii, 49
— peripheral, indications of, v, 216
— peripheral nerve injury and, vi, 251
— syphilitic, pathology of, xvii, 39
Neuroblastoma, vii, 150
Neurocytomata, xv, 370
Neurodermite, xvi, 141
Neurofibromatosis, diagnosis of, xvi, 26
— etiology of, xvi, 26
— pathology of, xvi, 26
— prognosis of, xvi, 27
— symptoms of, xvi, 25
— treatment of, xvi, 27
Neurological examination, routine, v, 8
Neuromuscular dysfunction, bladder, incidence of, xix, 201
— — signs and symptoms, xix, 201
— — treametnt of, xix, 202
Neurosyphilis, v, 81
— chorea and, xvii, 207
— clinical manifestations of, xvii, 185
— clinical diagnosis of, xvii, 249
— convulsions as a clinical manifestation of, xvii, 189
— cranial nerve involvement in, xvii, 196
— criteria of diagnosis of, xvii, 174
— eighth nerve involvement in, xvii, 197
— epilepsy and, xvii, 197
— general considerations of, xvii, 173
— gumma of brain and, xvii, 206
Neurosyphilis, hydrocephalus as a clinical manifestation of, xvii, 188
— incidence of, xvii, 175
— — age and, xvii, 177
— — race and, xvii, 175
— — sex and, xvii, 178
— — syphilis elsewhere in relation to, xvii, 179
— laboratory examination of spinal fluids in, xvii, 179
— late, tryparsamid treatment for, xvii, 269
— latent, xvii, 210
— meningitis as a clinical manifestation of, xvii, 186
— mental deficiency and, xvii, 199
— optic atrophy in, xvii, 196
— paralysis as a clinical manifestation of, xvii, 191
— paresis and, xvii, 199, 202
— spinal myelitis and, xvii, 207
— syphilitic dementia and, xvii, 199
— tabes and, xvii, 205
— treatment of, results of, xvii, 284
Neurotic heart, pregnancy and, i, 31
Neurotic women, anesthesia during labor in, i, 33
Neutralization of acids by body bases, hydrogen-ion concentration of blood maintained by, xx, 167
Neutromaltose, xii, 41
Neutrophils, age and possible variation in number of, xi, 38
— functions of, xi, 6
Nevi, iii, 333
— diagnosis of, xvi, 9
— etiology of, xvi, 10
— giant, xvi, 7
— lipoma associated with, xvi, 328
— lymphatic, xvi, 5
— pathology of, xvi, 10
— pigmentary, xvi, 5
— surgical aspects of, xv, 57
— symptoms of, xvii
— treatment of, xvi, 11
— types of, xvi, 1
— vascular, xvi, 1
Nevus anæmicus, xvi, 5
— albinismus differentiated from, xvi, 289

Nevus araneus, xvi, 3
Nevus flammeus, xvi, 2
Nevus linearis, xvi, 8
Nevus lipomatodes, xvi, 7
Nevus pigmentosus, iii, 333
Nevus pigmentosus et pilosus, xvi, 6
Nevus pilosus, xvi, 7
Nevus simplex, xvi, 3
Nevus spilus, xvi, 6
Nevus unius lateris, xvi, 8
Newborn, abnormalities of, i, 137, 138, 149
— abnormal urinary constituents in, iii, 274
— acid-base equilibrium inadequate in, ii, 99
— acidity of urine in, ii, 99
— acidosis in, ii, 98, 171
— acquired cardiovascular disease in, iii, 117
— acquired heart disease in, iii, 117
— acquired syphilis in, iii, 38
— acute fatty degeneration of, iii, 4
— — blood changes in, xx, 52
— acute infections of, iii, 18
— age, estimation of, ii, 160
— age limits embraced by the term, ii, 2
— alimentary tract of, physiology of, ii, 82
— — tumors of, iii, 193
— amount of urine in, xx, 4
— anal fissure in, iii, 196
— anal malformations in, iii, 166
— anatomy of, ii, 10; x, 51
— — peculiarities of, ii, 163
— anemia in, iii, 120
— anterior poliomyelitis in, iii, 31
— anthropometric data of, ii, 10, 13
— antitoxin content fo blood of, iii, 9
— appendicitis in, iii, 193
— artificial feeding of, ii, 157
— asphyxia in, i, 137, 170; ii, 189
— — diagnosis of, ii, 195
— — pathology of, ii, 192
— — symptoms of, ii, 193
— aspiration pneumonia in, ii, 195
— atelectasis in, iii, 87
— bacteriology in, ii, 117
— basal metabolism rate formula, xiii, 7
Newborn, bath of, time and temperature of, ii, 125
— bile-duct disorders in, iii, 201
— bile pigments in blood of, ii, 72
— birth injuries in, iii, 224
— bleeding time of blood of, ii, 66
— blood of, iii, 119
— — cellular elements in, ii, 67
— chemistry of, ii, 73, 77
— — physiology of, ii, 63
— blood-pressure in, ii, 56
— body proportions in, ii, 21
— body temperature of, ii, 48
— bones and joints of, iii, 278; vii, 153
— — influence of rickets on, vii, 153
— — morbid anatomy of, vii, 154
— brain anatomy in, iii, 212
— brain cysts in, iii, 250
— brain tumors in, iii, 250
— branchial cysts in, iii, 96
— branchial fistulæ in, iii, 96
— breast feeding, ii, 139
— bronchial diseases in, iii, 81
— bronchiectasis in, iii, 92
— bronchitis in, iii, 82
— bubonic plague in, iii, 30
— Buhl's disease in, iii, 4
— caput succedaneum in, iii, 391
— cardiovascular system of, iii, 100
— care of, i, 8, 136, 139, 171-174; ii, 121, 123
— cephalematoma in, iii, 392
— characteristics of disease of, ii, 6
— characteristics of urine in, xx, 3
— chemical composition of, ii, 46
— chemistry of blood of, ii, 73, 77
— chickenpox in, iii, 23
— cholelithiasis in, iii, 204
— chondrodystrophy in, vii, 11
— chronic infections of, iii, 38
— circulation of, physiology of, ii, 53
— circulation time in, ii, 56
— circumcision of, iii, 261
— cleft-palate in, iii, 131
— clothes and supplies for, i, 169, 171
— coagulation time of blood of, ii, 65
— collection of urine from, xx, 1
— colic in, iii, 177
— colon of, iii, 145
— color index in, ii, 65

Newborn, complemental feeding, ii, 155
— congenital debility and, ii, 160
— congenital dislocations in, iii, 288
— congenital esophageal atresia, iii, 135
— congenital jaw anomalies in, iii, 130
— congenital lingual anomalies in, iii, 130
— congenital pyloric stenosis in, iii, 139
— congenital stridor in, iii, 72
— congenital syphilis in, iii, 39, 59
— — treatment of, i, 83
— constipation in, iii, 179; viii, 221
— convulsions in, iii, 246; v, 129
— — seriousness of, ii, 7
— criteria of normality, ii, 10
— crying of, i, 138, 145
— cyanosis in, ii, 203
— — seriousness of, ii, 7
— cystic hygroma in, iii, 97
— cystic kidneys in, iii, 267
— death causes during first 14 days, ii, 5
— decreased alkalinity of blood in, ii, 171
— development of immunity in, iii, 8
— diarrhea in, iii, 175
— — unimportance of, ii, 7
— difficult feeding cases, ii, 150
— digestive equipment of, xii, 54
— digestive system of, iii, 124, 171
— — diseases of, iii, 188
— diphtheria in, iii, 23
— drugs during labor and, ii, 123
— ductless glands of, iii, 371
— ductus venosus of, iii, 129
— duration of gestation and weight and height of, x, 92
— dysentery in, iii, 30
— ear of, iii, 354, 369
— electrocardiography in, ii, 60
— — asphyxia neonatorum diagnosed by, ii, 195
— emphysema in, iii, 90
— empyema in, iii, 95
— encephalitis lethargica in, iii, 31
— encephalocele in, iii, 214
— endocarditis in, iii, 117
— enteritis in, iii, 191
Newborn, eosinophilia in, xx, 35
— epispadias in, iii, 267
— erysipelas in, iii, 18; xiv, 400
— esophagus of, iii, 124
— estimation of fetal age, ii, 160
— extremity deformities in, iii, 283
— eyes of, iii, 354
— — care of, i, 62, 137, 169; ii, 124
— — characteristics of, ii, 7
— facial paralysis in, iii, 229
— fatty degeneration in, iii, 4
— fractures in, i, 121, 124, 127
— — arm, i, 123
— clavicular, i, 121, 123
— — paralysis and, i, 127
— treatment of, illus., i, 123
— frequency of prematurity, ii, 163
— gall-bladder of, iii, 129
— — disease in, iii, 201
— gangrenous inflammation of dental pulp in, iii, 191
— gastro-intestinal tract of, iii, 129
— general physiology of, ii, 32
— genital hemorrhage in, iii, 269
— genitalia of, iii, 259
— genito-urinary tract of, iii, 258
— infections of, iii, 270
— German measles in, iii, 28
— gonococcus infection in, iii, 30
— growth of, ii, 39
— harelip in, iii, 131
— hearing of, ii, 7, 115
— heat loss *per diem*, ii, 38
— hematocele in, iii, 263
— hemoglobin percentage in, ii, 64; xx, 27
— hemorrhage in, iii, 180
— — upper respiratory tract, iii, 80
— hemorrhage in central nervous system of, i, 118, 119, 120
— hemorrhagic diseases of, ii, 228; iii, 119
— — blood changes in, xx, 51
— — blood-count in, xi, 179
— — case history of, xi, 178
— — clinical picture of, xi, 179
— — confusing the diagnosis of syphilis, i, 63
— — diagnosis of, ii, 237; xi, 180
— — etiology, xi, 177
— — pathology of, ii, 235

Newborn, hemorrhagic diseases of, precocity of, ii, 7
— — prognosis of, ii, 238
— — symptoms of, ii, 235
— — treatment of, ii, 238; xi, 181
— hemorrhoids in, iii, 196
— hereditary hemolytic icterus and, ii, 224
— hermaphroditism, iii, 268
— hernia in, iii, 156
— Hirschsprung's diseases in, iii, 152
— hunger sensation in, ii, 116
— hydrocele in, iii, 262
— hydrocephalus in, iii, 219
— hydrogen-ion values in, ii, 98
— hydromelia in, iii, 223
— hydronephrosis in, iii, 267
— hypospadias in, iii, 266
— hypostatic hyperemia in, iii, 90
— icterus neonatorum, ii, 213
— identification of, ii, 126
— idiocy in, iii, 251
— infantile cerebral paralysis, iii, 223
— infectious diseases of, iii, 7
— influenza in, iii, 29
— initial diarrhea of, ii, 93
— institution of breast nursing, ii, 146
— interval between breast feedings, ii, 147
— intestinal parasites and, iii, 35
— intestines of, physiology of, ii, 89
— intracranial hemorrhage in, iii, 230
— intussusception in, iii, 196
— joints and bones of, iii, 278
— kidney of, iii, 258
— — birth injuries of, iii, 269
— — physiology of, ii, 100
— length of, race and sex influencing, iv, 17
— leprosy in, iii, 64
— leukemia in, iii, 121
— liver of, iii, 128
— — diseases of, iii, 199
— — physiology of, ii, 88
— — size of, ii, 213
— longest recorded, ii, 19
— lung affections in, iii, 81
— lung volume of, ii, 53
— lymphatic glands of, iii, 397
— malaria in, iii, 34
— mammary glands of, iii, 398
Newborn, management of prematurity, ii, 176
— massive hemorrhage in, v, 23
— measles in, iii, 26
— measuresments of, ii, 13, 18
— Meckel's diverticulum in, iii, 164
— medicinal treatment of prematurity in, ii, 186
— megacolon in, iii, 152
— meningitis in, iii, 243
— meningocele in, iii, 214
— metabolism in, ii, 95
— microcolon in, iii, 151
— mongolism in, iii, 251
— mortality of, ii, 3
— — prematurity and, ii, 176
— mouth of, iii, 124
— — physiology of, ii, 82
— mumps in, iii, 28
— muscles of, malformations in, iii, 310
— — physiology of, ii, 109
— nephritis in, iii, 273
— nervous system of, anatomy of, iii, 212
— — physiology of, ii, 109
— nitrogen balance in, ii, 95
— nitrogen content of blood of, ii, 76
— normal blood picture in, xi, 39
— nose diseases in, iii, 76
— opsonic index in, iii, 8
— orchitis in, iii, 272
— ovaries of, iii, 260
— pancreas of, iii, 128
— — physiology of, ii, 89
— pancreatic diseases in, iii, 204
— paratyphoid fever in, iii, 29
— peculiarities of disease in, ii, 171
— pemphigus of, xvi, 210
— pericardium of, iii, 118
— peritoneal diseases in, iii, 205
— peritonitis in, xv, 298
— pharyngeal diseases in, iii, 76
— phosphorous compounds in blood of, ii, 79
— physiology of, ii, 32
— — peculiarities in, ii, 163
— physiology of respiratory system of, iii, 66
— platelet-counts in, xx, 35
— pleura of, diseases of, iii, 93

Newborn, pneumonia of, iii, 83
— postnatal examination of, i, 160
— potentiality of acidosis in, ii, 99
— prematurity, ii, 160
— — breast milk supply for, i, 157
— — mortality in, ii, 176
— — nervous system in, ii, 168
— prenatal care and, i, 7
— — symptoms of, ii, 172
— — syphilis and, i, 79
— prenatal hygiene and, ii, 121
— problems encountered and met, ii, 8
— prostate of, iii, 259
— pulse rate of, ii, 55, 62
— pyelitis in, iii, 270
— — symptoms of, xix, 146
— reaction of urine in, xx, 4
— rectal malformations in, iii, 166
— red blood-corpuscles in, xx, 28
— renal hemorrhaeg in, iii, 269
— resistance to stimuli, v, 129
— respiration of, anatomy and physiology of, ii, 52
— respiratory quotient for, ii, 96
— respiratory system of, iii, 66
— salivary glands of, iii, 124, 196
— scarlet fever in, iii, 26
— secretions of, ii, 110
— — physiology of, ii, 109
— sense organs of, ii, 114
— sepsis neonatorum, iii, 12
— sepsis of, jaundice in, xv, 311
— sex influence on weight, ii, 17
— right of, ii, 114
— size changes seen early in, ii, 32
— skin of, iii, 315
— — care of, ii, 127
— — physiology of, ii, 109
— — *See also* Volume xvi
— skull malformations in, iii, 279
— small intestine of, iii, 145
— smallpox in, iii, 20
— smell in, ii, 115
— — deficiency in, ii, 7
— source of infection in, iii, 10
— special senses of, physiology of, ii, 109
— specific gravity of blood of, ii, 65
— spina bifida in, iii, 217
— spinal cord of, anatomy of, iii, 212
— — diseases of, iii, 248
Newborn, spinal cord of, injuries of, iii, 225
— spleen of, iii, 121
— starvation fever in, viii, 101
— stomach of, iii, 125
— — capacity of, viii, 87
— — physiology of, ii, 84
— stools of, ii, 91; viii, 142; xx, 71
— suprarenal glands of, iii, 386
— syphilis in, i, 63, 76; iii, 38
— — osteochondritis and, i, 70-73
— — treatment of, i, 81-83
— — Wassermann reaction and, i, 78
— taste in, ii, 115
— testes of, iii, 259
— tetanus in, iii, 31; xiv, 301
— thirst sensation in, ii, 116
— thrush in, iii, 190
— thymus of, iii, 371
— thyroid gland of, iii, 379
— tonsillar diseases in, iii, 76
— transfusion in, xi, 181
— transitory fever in, ii, 208
— trunk deformities of, iii, 281
— tuberculosis in, iii, 60; xiv, 339
— tumors of bronchi and lungs, iii, 86
— typhoid fever in, iii, 29
— ulcers of alimentary tract in, iii, 194
— umbilicus of, iii, 399
— ureters of, iii, 258
— urethra of, iii, 259
— urinalysis in, importance of, xx, 1
— urinary bladder of, iii, 258
— urinary constituents in, ii, 102
— urinary tract of, physiology of, ii, 100
— urine passed in first 3 days, ii, 37
— urine reaction in, ii, 99
— uterus of, iii, 260
— vagina of, iii, 260
— vascular disease in, iii, 118
— viscosity of blood of, ii, 65
— volume of blood in, xx, 31
— vomiting in, iii, 171
— vulvovaginitis in, iii, 271
— volvulus in, iii, 196; viii, 237
— weight of, average, ii, 14, 16
— — race and sex influencing, ii, 17; iv, 17
— weight loss in, ii, 34

Newborn, weight loss in, per cent of, ii, 35
— weight-sex data, ii, 17; iv, 17
— white blood-corpuscles in, xx, 34
— whooping-cough in, iii, 28
— Winckel's diseases in, iii, 1
Newborn period, length of, x, 50
Newgrowths, skin, xvi, 315
— — malignant, xvi, 331
New York City Department of Health, maternity protection campaign of, i, 155
Night gown, infant, ii, 129
Night sweats, tuberculosis and, ix, 229
Night-terrors, adenoids and, ix, 70, 72
Nikolsky's sign, pemphigus and, xvi, 100
Nipples, abnormalities of, nursing and, xii, 190
— care of, i, 141, 142, 172
— chancre of, xvii, 236
— cracked, treatment of, i, 143
— manual expression of, i, 142, 143, 145, 146
— nursing, i, 171
— pathology of, nursing prevented by, ii, 152
— preparation for use of, xii, 164
— reduction in number of milk ducts leading to, ii, 153
— shields for, i, 143
Niter paper, asthma and, ix, 115
Nitritoid crisis, arsphenamin injections followed by, xvii, 271
Nitrobenzol, Winckel's disease and, iii, 2
Nitrogen, amino-acid, ii, 78
— ammonia, ii, 78
— nonprotein, ii, 76, 146
— — blood and, ii, 76; xx, 129
— total, ii, 102
— urea, ii, 102
— urine and, ii, 102
Nitrogen equilibrium, xiii, 15
— newborn, ii, 95
— positive, xiii, 15
Nitrogen partition examination, high blood-pressure of pregnancy and, i, 22
Nitroglycerin, acute decompensation and, i, 32
Nitrous oxid, use during labor, ii, 123
Nocturnal enuresis, xix, 51
— diffuse glomerulonephritis and, xix, 117
Nodal rhythm, electrocardiographic determination of, xviii, 173
Nodding spasm, v, 58
Nodular leprosy, xvi, 244
Nodules, subcutaneuos, rheumatic, xviii, 19, 69
Noguchi's globulin reagent, xx, 98
Noguchi test, globulin in cerebrospinal fluid and, v, 16; xvii, 55
Noguchi-Wassermann test, relative value of Kahn test and, xx, 69
Noma, viii, 30
Nomenclature for cardiac diagnosis, xviii, 237
Nona, synonyms of, xiv, 254
Non-infectious arthritis, acute, vii, 86
Non-infectious synovitis, acute, vii, 86
Nonne test, globulin in spinal fluid and, xvii, 54
Non-protein nitrogen, blood and, ii, 76
— milk containing, ii, 146
— significance in blood, xx, 129
Non-purulent glomerulonephritis, embolic, xix, 106
Non-suppurative tenosynovitis, vii, 261, 263
Non-thrombopenic purpura, idiopathic, case history of, xi, 205
— — course of, xi, 209
— — diagnosis of, xi, 208
— — etiology of, xi, 205
— — physical signs of, xi, 207
— — symptoms of, xi, 206
— — treatment of, xi, 209
— secondary, case history of, xi, 210
— — diagnosis of, xi, 211
— — etiology of, xi, 209
— — treatment of, xi, 212
Non-tuberculous bronchial glands, enlarged, diagnosis of, ix, 209
— — incidence of, ix, 206
— — physical examination of, ix, 207
— — symptoms of, ix, 206
— — treatment of, ix, 209
Non-union, orthopedic management of, vi, 174

Normal child, average weight-height of, tables of, x, 111-114
— caloric requirements of, x, 125
— day's dietary for, two years, x, 126
— — five years, x, 127, 128
— — seven years, x, 129, 130
— — nine years, x, 131, 132
— — twelve years, x, 133
— fat distribution in, x, 101
— food for, x, 117
— — bread, x, 124
— — desserts, x, 124
— — cereals, x, 123
— — eggs, fish, meat, x, 124
— — fats, x, 124
— — fruits, x, 123
— — milk, x, 123
— — soups, x, 124
— — vegetables, x, 123
— general appearance of, x, 109
— habits of feeding of, x, 121
— muscle tone of, x, 109
— posture of, x, 102
— skin of, x, 101
— standard of, x, 90
— weight of, x, 99
Normal daily liquid intake for infants, xiii, 42
Normal infants, average daily caloric requirement of, xii, 67
— essential points in feeding of, xii, 64
— food requirements of, xii, 57
— formula changes in, xii, 76
— — carbohydrates, xii, 85
— — fats, xii, 81
— — general cosiderations of, xii, 89
— — protein, xii, 88
— nutritional characteristics of, xii, 5
— types of, xii, 72
Normal metabolism, basal (standard) metabolism, xiii, 2
— carbohydrate, xiii, 13
— fat, xiii, 15
— growth, xiii, 17
— metabolism apparatus, xiii, 1
— protein, xiii, 14
— salts, xiii, 15
Normoblasts, characteristics of, xi, 12
— significance of, xi, 15
Norms, Binet-Simon, 78
Nose, accessory sinuses of, disease of, ix, 21
— anatomy of, ix, 1, 22
— cleansing of, ii, 126
— diphtheria bacilli found early in, ii, 117
— diseases of, accessory sinus disease, ix, 21
— — acute rhinitis, ix, 1
— — atrophic rhinitis, ix, 13
— — chronic rhinitis, ix, 10
— — diphtheritic rhinitis, ix, 16
— — epistaxis, ix, 17
— — hemorrhage, ix, 17
— — hypertrophic rhinitis, ix, 12
— — nosebleed, ix, 17
— — syphilitic rhinitis, ix, 15
— — traumatic rhinitis, ix, 17
— — tuberculous rhinitis, ix, 16
— — vasomotor rhinitis, ix, 117
— functions of, ix, 1, 3
— meningitis from infection of, v, 85
— newborn, anatomy of, iii, 66
— — hemorrhage from, iii, 80
— — infections of, iii, 77
— — malformations of, iii, 76
— — non-luetic snuffles, iii, 77
— — physiology of, iii, 66
— secretions of, examination of, xx, 91
— tuberculosis of, xiv, 350
Nosebleed, ix, 17
Nuchal arm injuries at birth, i, 121, 123
Nuclear icterus, ii, 222
Nucleic acid injections, puerperal sepsis treated with, i, 103
Nucleoprotein, xx, 6
Nurseries, attendants in, ii, 138
— day, factories and, i, 156
— hygienic considerations of, ii, 130
Nursery schools, v, 181
— hygiene and, iv, 92
Nurses, maternity, i, 157, 161, 165, 174
— — factory day nurseries and, i, 156
— — prenatal care and, i, 10
— public health, child hygiene and, iv, 175
— — maternity care and, i, 17, 155, 158, 174, 175
— — midwives and, i, 154

Nurses, training for, i, 159
— septic patients and, i, 98
— wet, i, 157
Nursing, i, 139-148
— acute rhinitis interfering with, ix, 5
— anemia and, iv, 48
— breast, institution of, ii, 146
— — interval between, ii, 147
— colic and, i, 145
— contra-indications for, iv, 48
— — tuberculous women and, i, 26, 29
— early neonatal, i, 136
— infant, cleft-palate and harelip and, viii, 9
— — difficulties encountered in, viii, 97
— insanity and, iv, 48
— malignancy and, iv, 48
— management of, xii, 170
— nephritis and, iv, 48
— physiology of, xii, 156
— prematurity and, ii, 180
— standards of successful, xii, 184
— syphilis and, iv, 48
— syphilitic infants and, i, 66
— tuberculosis contra-indicating, i, 26, 29; iv, 48
— typhoid fever and, viii, 192
Nursing infant, carbohydrate requirement of, x, 17
— fat ingestion by, x, 30
— fat requirement of, x, 15
— protein requirement of, x, 12
— water requirement of, x, 19
Nursing intervals, iv, 45
Nutrient principles, x, 21
Nutrition, acidosis and, x, 268
— additions to breast feeding and, iv, 48
— alkalosis and, x, 275
— bone disorders and, vi, 182
— chemical composition of food materials, x, 286-289
— colostrum and, ii, 73
— complemental feeding and, iv, 49
— contra-indications for nursing, iv, 48
— definition of, x, 51
— disease of, acute or florid scurvy, x, 224
— — beriberi, x, 264
Nutrition, disease of, endemic multiple neuritis, x, 264
— — latent scurvy, x, 222
— — pellagra, x, 254
— — rickets, x, 229
— — scurvy, x, 218, 224
— — spasmophilia, x, 248
— — subacute scurvy, x, 223
— — tetany, x, 248
— effects of inanition and malnutrition, x, 199
— eruption time of teeth as index to, x, 106
— faulty, prematurity caused by, ii, 162
— fetal, prenatal growth and, x, 46
— food for normal child and, x, 117
— forms and sources of food, x, 10, 26
— inanition, malnutrition and, x, 155
— infant, breast feeding and, i, 139-148
— influence of food on human development, x, 1
— normal child defined, x, 90
— normal child's, four main criteria of, x, 110
— posture and, x, 105
— prenatal, x, 42
— preventive pediatrics and, iv, 39
Nutrition, prognosis of heart disease and, xviii, 207
— romance of, x, 9
— science of, x, 7
— supplemental feeding, iv, 50
— surgical prognosis and, xv, 2
— types of infants and, xii, 4, 72
— underfeeding and, iv, 45
— vitamin content of various foods, x, 283-285
— wizardry of, x, 8
Nutritional bone disorders, osteomalacia, vi, 187
— rickets, vi, 182, 187
— scurvy, vi, 188
Nutritional diseases, anemia secondary to, xi, 63
— — blood changes due to, xx, 49
— blood-count in, xi, 54
Nuts, caloric value of, x, 193
— chemical content of, x, 289
— vitamin content of, x, 285

Nux vomica, tonic use of, respiratory diseases and, ix, 267
Nystagmus, albinism and, iii, 359
— brain tumors causing, v, 118
— cerebrospinal meningitis complicated by, xiv, 283
— congenital, v, 58
— Friedreich's ataxia and, vi, 250
— syphilis and, iii, 49
— tentorial tear and hemorrhage causing, v, 46
Nystagmus reflex, ii, 115

Obedience, preventive pediatrics and, iv, 77
Obesity, achondroplasia and, xiii, 149
— definition of, x, 147
— endocrines and, x, 151
— heredity and, x, 149
— metabolism of, xiii, 137
— mentality and, x, 152
— pituitary disease causing, xilii, 79
— sex and, x, 152
— treatment of, x, 152; xiii, 138
Obstetric fractures, clavicle, xv, 74
— femur, xv, 74
— humerus, xv, 69
Obstetric package, sterile, i, 170
Obstetrical paralysis, diagnosis of, vi, 245
— etiology of, vi, 243
— general considerations of, iii, 225; vii, 256
— pathology of, vi, 243
— peripheral nerve injuries and, vi, 251
— symptoms of, vi, 244
— treatment of, vi, 245
Obstetrical paralysis of arm, treatment of, v, 27
Obstetrician, asepsis of, i, 86
— induction of labor by, i, 110
— nursing instructions by, i, 139, 141
— trained, i, 18, 42, 149, 150, 158, 162
Obstetrics, complications of, i, 151
— hospital, i, 154, 158, 162
— infant deaths due to, i, 8
— pediatrics and, ii, 2, 121
— prenatal care and, i, 16
Obstetrics, teaching of, improvement in, i, 16, 112, 150
Obstruction, intestinal, acquired, iii, 196
— — general considerations of, viii, 233
— respiratory, cyanosis caused by, ii, 205
Obstructive jaundice, bile pigments in urine in, xx, 12
— icterus index in, xx, 40
Occult blood, stool and urine tested for, viii, 343
Occupation, maternal, gestation and, iv, 16
Ocular disturbances, congenital syphilis and, i, 76
— eclampsia and, i, 39
— gonococcal infection and, i, 62, 94
— pregnancy and, i, 168
— toxemias of, i, 37
— prenatal care and, i, 16
Ocular paralysis, tentorial tear with hemorrhage causing, v, 46
Oculocardiac reflex, newborn, ii, 113
Oertliche Roetheln, synonyms of, xiv, 320
Oïdium albicans, xvi, 343
— thrush and, viii, 20; xx, 92
— thrush caused by, iii, 190
Oil, castor, respiratory diseases and purgative use of, ix, 263
— cod-liver, respiratory diseases and tonic use of, ix, 267
— — rickets and, x, 232, 233
— — rickets treated by, x, 244
— — tetany and spasmophilia and, x, 252
— — vitamin content of, x, 22, 24
— mineral, respiratory diseases and laxative use of, ix, 263
— vitamin content of, x, 284
Ointments, skin, xvi, 346, 347
Old tuberculin, von Pirquet test with, xiv, 336
Oleic acid, ii, 47
Oligodactylia, iii, 285
Ollier-Thiersch skin grafts, scar contractures and, vi, 205
Ombredanne, rectal prolapse repair of, xv, 347

Ombredanne, trans-scrotal operation of, xv, 270
Omentum, cysts of, treatment of, xv, 338
Omphalitis, iii, 404
Omphalomesenteric duct, Meckel's diverticulum and, viii, 245
— persistence of, iii, 164
Oncotic pressure, edema and, xix, 76
— nephrosis and, xix, 86
Onions, bottle feeding supplemented by, xii, 134
Onychauxis, xvi, 264
Onychia, syphilitic, vii, 141
Onychogryphosis, xvi, 265
Onychophagia, xvi, 266
Onychorrhexis, xvi, 269
Opaque oil injection, neurological examination and, v, 122
Open type metabolism apparatus, xiii, 1
Operations, pregnancy and, abortion following, i, 41
— dystocia and, i, 19
— inertia necessitating, i, 91
— pelvic examination and, i, 19
— sepsis following, i, 87, 90, 91, 104
— shock prevention and, i, 131
Ophthalmia neonatorum, gonorrhea and, i, 61; iii, 364
— non-gonorrheal, iii, 363
— prenatal care preventing, i, 16
Ophthalmoscope, brain tumors and, v, 118
— neurological examination and, v, 17
— tubercles of choroid and, v, 96
Opiates, therapeutic use of, respiratory diseases and, ix, 263
Opisthotonos, neurosyphilis and, xvii, 186
Opium, accidental poisoning with, viii, 313
— acute intestinal indigestion and, viii, 172
— dermatitis caused by, xvi, 48, 52
— in ovariotomies, i, 41
— myomectomy and, i, 42
— ovariotomies and, i, 42
— typhoid fever and, viii, 193
Oppenheim's amyotonia congenita, iii, 248
Opsonic index, mother and newborn, iii, 8
Opsonins, definition of, xiv, 4
Optic atrophy, general considerations of, v, 17
— hereditary syphilis and, xvii, 250
— heredity and, iv, 8
— latent syphilis and, xvii, 226
— neurosyphilis and, xvii, 196
Optic discs, examination of, v, 18
Optic neuritis, cerebrospinal meningitis complicated by, xiv, 283, 293
— congenital syphilis causing, iii, 49
— mumps causing, xiv, 149
— syphilitic, early manifestations of, xvii, 138
Optic thalamus, disorders affecting, v, 218
— icterus and, ii, 223
Optic vesicles, anomalies of eye due to malformations of, iii, 355
Oral secretions, examination of, xx, 91
Orange juice, antiscorbutic vitamin in, v, 125
— bottle feeding supplemented by, xii, 131
— prematurity demanding, ii, 186
— scurvy and, vii, 214; xiii, 127
— scurvy treated by use of, x, 227
— vitamin content of, x, 23
Orbit, special differences between adult and infant, vii, 7
Orbital cellulitis, accessory nasal sinus disease and, ix, 34
Orbitonasal fissure, anomalies due to malformations of, iii, 359
Orchitis, acute, xv, 371
— — symptoms and treatment of, xix, 216
— congenital syphilis and, iii, 59
— general considerations of, iii, 272
— mumps and, iv, 141; xiv, 147
— syphilitic, xv, 48, 372
— — diagnosis of, xix, 218
— — incidence of, xvii, 138
— tuberculous, diagnosis of, xix, 217
— — incidence of, xix, 216
— — treatment of, xix, 217
Orecchioni, synonyms of, xiv, 141

Orthodiagrams, size of heart determined by, xviii, 149
Orthopedics, acute joint affections in, vi, 50
— affections encountered in, classification of, vi, 47
— apparatus used in, vi, 26
— bone affections and, vi, 128, 147, 182
— congenital anomalies and, vi, 273
— derivation of the word, vi, 1
— examinations in, vi, 5, 7
— — ankle, vi, 12
— — foot and ankle, vi, 12
— — hip, vi, 15
— — knee, vi, 12
— — sacro-iliac joint and, vi, 20
— — spine and, vi, 22
— — upper extremity, vi, 25
— history taking in, vi, 5
— low-grade joint affections and, vi, 68, 72, 85, 98
— nervous system affections and, vi, 218, 237
— soft tissue affections and, vi, 201, 210
— static deformities and, vi, 256
— traumatic joint affections and, vi, 118
Orthostatic albuminuria, diagnosis of, xix, 61
— incidence of, xix, 61
— prognosis of, xix, 62
— significance of, xx, 7
— treatment of, xix, 62
Os calcis, apophysitis of, diagnosis of, vii, 80
— — etiology of, vii, 79
— — pathology of, vii, 80
— — symptoms of, vii, 80
— — treatment of, vii, 80
— epiphysitis of, vi, 144
Osgood-Schlatter's disease, etiology of, vii, 77
— general considerations of, vii, 75; xv, 141
— symptoms of, vi, 146; vii, 78
— treatment of, vi, 146; vii, 79
Osler's nodules, prognosis of heart disease and, xviii, 210
— subacute bacterial endocarditis and, xviii, 189, 190
Ossification, bone, syphilitic infants and, i, 71
— centers of, vii, 2, 3
— — number of, x, 51
— — prematurity distinguished by, ii, 164
— fetal chondrodystrophy and, vii, 18
— intracartilaginous, vii, 3
— intramembranous, vii, 2
— process of, vii, 2
Ossifying myositis, vi, 213
Osteitis, chronic, aural, congenital syphilis and, i, 76
— saber tibia and, syphilis and, i, 73
— syphilitic, xvii, 157
— traumatic, vi, 181
— tuberculosis of spine differentiated from, vi, 91
Osteitis deformans, blood changes in, xx, 48
— general considerations of, vii, 80
Osteitis fibrosa, foot and ankle tuberculosis differentiated from, vi, 77
Osteitis fibrocystica, vii, 80
Osteitis fibrosa cystica, general considerations of, xv, 123
— occurrence of, vi, 142
— treatment of, vi, 143
Osteo-arthropathy, pumonary, hypertrophic, vii, 80
Osteochondritis, acute syphilitic, symptoms of, vii, 141
— intra-articular, vi, 107
— Köhler's, etiology of, vii, 75, 77
— — scaphoid, vii, 77
— — treatment of, vii, 77
— spinal, vi, 114
— syphilitic, iii, 45; vi, 137
— — incidence of, xvii, 131
— — infants and, i, 70-73
— tarsal navicular, vii, 77
Osteochondritis deformans juvenilis, diagnosis of, vii, 76
— etiology of, vii, 73
— pathology of, vii, 76
— symptoms of, vii, 76
— treatment of, vii, 77
— x-ray examination of, vii, 76
Osteochondritis dissecans, vii, 80

Osteochondritis juvenilis, tuberculosis of joints differentiated from, vi, 71
Osteochondroma, joints and, vi, 126
— multiple, vi, 192
— treatment of, vi, 192
Osteogenesis imperfecta, characteristic lesions of, vii, 29
— clinical types and symptoms of, vii, 31
— diagnosis of, vii, 44
— etiology of, vii, 30; xiii, 165
— fragilitas ossium differentiated from, vi, 190
— pathology of, vii, 41, 42
— symptoms of, vii, 30; xiii, 166
— synonyms of, xiii, 164
— treatment of, vii, 44; xiii, 167
— x-ray studies of, vii, 43
Osteogenesis imperfecta congenita, iii, 299
Osteogenetic fibers, vii, 2
Osteogenic sarcoma, general considerations of, vii, 162
— types of, vi, 197
Osteogingivitis gangrenosa neonatorum, iii, 191
Osteoma, exostoses and, xv, 125
— joints and, vi, 126
— solitary, character of, vii, 160
Osteomalacia, characteristics of, vii, 44, 45
— etiology of, xiii, 165
— late rickets and, xx, 177
— orthopedic management of, vi, 187
— osteitis fibrosa cystica and, vi, 143
— symptoms of, xiii, 166
— synonyms of, xiii, 164
— treatment of, xiii, 167
Osteomyelitis, acute, acute rheumatic fever differentiated from, vii, 96
— — age and sex incidence of, xv, 131
— — anatomical considerations of, xv, 129
— — clinical features of, xv, 133
— — diagnosis of, vi, 131; xv, 135
— — epiphysitis and, xv, 137
— — etiology of, vi, 128; xv, 130
— — foot and ankle tuberculosis differentiated from, vi, 76
— — infants and, xv, 137
Osteomyelitis, acute, local manifestations of, vi, 129
— — pathology of, vi, 128; xv, 132
— — postoperative care of, xv, 136
— — prognosis of, vi, 133; xv, 136
— — scurvy differentiated from, xiii, 125; xv, 39
— — Still's disease differentiated from, vii, 105
— — symptoms of, vi, 129
— — treatment of, vi, 135; xv, 135
— — tuberculosis of joints differentiated from, vi, 71
— — x-ray and, vi, 130
— acute suppurative, acute epiphysitis type of, vii, 69
— — course of, vii, 69
— — etiology of, vii, 64
— — pathology of, vii, 65
— — symptoms of, vii, 68
— anemia due to, xx, 50
— blood-count in, xi, 70
— chronic, vii, 69
— — clinical signs of, vii, 71
— — complications of, vii, 71
— — treatment of, vii, 72, 73; xv, 139
— — x-ray diagnosis of, vii, 72
— chronic fibrous, vii, 80
— degenerative nephritis associated with, xx, 152
— Garré's sclerosing, diagnosis of, vi, 141
— — local manifestations of, vi, 139
— — pathology of, vi, 139
— — prognosis of, vi, 141
— — symptoms of, vi, 139
— — treatment of, vi, 141
— localized, clinical signs of, vii, 71
— — complications of, vii, 71
— — sequelæ of, vii, 73
— — treatment of, vii, 72
— — x-ray diagnosis of, vii, 72
— newborn, iii, 79, 308
— perinephritic abscess differentiated from, xix, 176
— pyogenic, tuberculosis of bones and joints differentiated from, vii, 117
— scurvy differentiated from, vii, 211
— septic, typhoid fever differentiated from, xiv, 200

Osteomyelitis, subacute, treatment of, xv, 139
— syphilitic, vi, 138
— tuberculous, syphilitic variety differentiated from, vii, 150
— typhoid, viii, 191
Osteomyelitis fibrosa, vii, 80
Osteoperiostitis, acute, acute osteomyelitis and, vii, 64
— acute syphilitic, case histories of, vii, 147
— late inherited syphilis and, xvii, 154
— syphilitic, xv, 48
— — incidence of, xvii, 154
— — skull, signs of, xvii, 137
— — treament of, xvii, 281
Osteoplastic flap resection, head injuries at birth and, i, 113
Osteoporosis, vi, 181
Osteopsathyrosis, characteristic lesions of, vii, 29
— clinical types and symptoms of, vii, 31
— diagnosis of, vii, 44
— etiology of, vii, 30; xiii, 165
— fragilitas ossium differentiated from, vi, 190
— heredity and, iv, 8
— pathology of, vii, 41, 42
— symptoms of, vii, 30; xiii, 166
— synonyms of, xiii, 164
— treatment of, vii, 44; xiii, 167
— x-ray studies of, vii, 43
Osteosclerosis, congenital, vi, 191
Osteotomy, contractures from brachial paralysis and, v, 33
— coxa vara treated by, vi, 114
Otitis media, accessory nasal sinus disease and, ix, 34
— acute bronchitis and, ix, 104
— acute follicular tonsillitis causing, ix, 54
— acute rhinitis causing, ix, 6
— adenoids and, ix, 71
— blood-count in, xi, 48
— bronchopneumonia and, ix, 130
— chronic rhinitis and, ix, 12
— convulsions and, v, 137
— diphtheritic, xiv, 165
— hypertrophic rhinitis and, ix, 12
— lobar pneumonia causing, ix, 160
Otitis media, malnutrition and, x, 188
— peritonsillar abscess causing, ix, 65
— scarlet fever complicated by, xiv, 20
— — treatment of, xiv, 29
— scurvy and, xiii, 126
— tonsillectomy and, ix, 60
— tuberculous, xiv, 349
— typhoid fever and, viii, 190
— typhoid fever complicated by, xiv, 199
Ovarian tubes, excision of, sterilization of the tuberculous and, i, 29
— gonorrhea and, i, 61, 88, 94
— puerperal fever and, i, 95
Ovaries, anatomy of, iii, 260; xix, 19
— anomalies and malformations of, iii, 263
— cysts of, i, 41; iii, 276
— development of, xix, 5
— gonorrhea and, i, 61
— irradiation of, fetal abnormalities caused by, i, 67
— syphilis and, i, 67
— tumors of, diagnosis of, xix, 224
— — general considerations of, i, 41
— — incidence of, xix, 223
— — prognosis of, xix, 224
— — treatment of, xv, 337
Ovariotomy, i, 41
Overdevelopment, Fröhliche's syndrome and, x, 143
— obesity and, x, 147
— treatment of, x, 152
— underdevelopment and, x, 134, 142
Overeating, result of mother, xii, 186
Overfatigue, dangers of, iv, 85
— tuberculosis and, iv, 144
Overfeeding, causes of, iv, 47
— fats and, xii, 86
— food requirements and, xii, 61
— intervals and, xii, 138
— signs of, xii, 77
— vomiting a sign of, ii, 186
Overweight, food requirements in premature and, xii, 96, 102, 107
Overweight children, nutritional characteristics of, xii, 5
Overwork, prematurity caused by, ii, 162

Ovum, syphilitic infection of, i, 64, 66, 67
Oxalic acid, urine and, ii, 107
Oxidase blood stain, xx, 41
— technic of, xi, 29
Oxidation, carbohydrate, x, 16
Oxybutyric acid, carbohydrate deficiency and, x, 16
Oxycephalia, vii, 54
Oxygen, acquired or extra-uterine asphyxia and use of, ii, 201
— acute bronchitis and, ix, 105
— atelectasis and, iii, 90
— bronchopneumonia and, ix, 136
— cyanosis caused by deficiency of, ii, 203, 207
— hemorrhagic disease and deficiency of, ii, 232
— lobar pneumonia and, ix, 165
— method of therapeutic use of, respiratory diseases and, ix, 281
Oxygen insufflation, asphyxia neonatorum and, ii, 199
Oxygen unsaturation, cyanosis and, ii, 204
Oxyuris vermicularis, general considerations of, xvi, 171
— intestinal infestation with, viii, 296
— morphology and identification of, xx, 79
Ozena, ix, 13
— late inherited syphilis and, xvii, 171

Pacemaker derangement, electrocardiographic determination of, xviii, 172
Pachymeningitis hæmorrhagica interna, congenital syphilis and, iii, 59
— general considerations of, v, 84
Pachyonychia congenita, xvi, 266
Pack, cold, therapeutic use of, respiratory diseases and, ix, 259
Packing of vagina, i, 97
— abortion and, i, 29, 47
— asepsis of, i, 135
— placenta prævia and, i, 60
— tamponade, i, 29
— — abortion and, i, 48
— — abruptio placentæ and, i, 32, 56
Packing of vagina, tamponade, labor induction and, i, 110
— — placenta prævia, i, 59, 60
Pads used during labor, i, 170
Paget's disease, vii, 80
Pain, abdominal, acute rheumatic fever causing, xviii, 54
— — causes of obscure types of, viii, 269
— abruptio placentæ and, i, 54, 55
— acute cystoma and, i, 42
— breast feeding and, i, 140
— fibromyomata and, i, 44
— "growing," rheumatic infection and. xviii, 72
— heart, i, 30, 31
— lower back, i, 169
— neuralgic, toxemias and, i, 37
— precordial, acute rheumatic fever causing, xviii, 53
— premature initiation of labor and, i, 109
— reaction of infant to, iv, 65
— rheumatic pericarditis causing, xviii, 82
— sensation present at birth, ii, 115
Painful and weak backs, vii, 277
Painful nipple, hysteria causing, ii, 152
Palatal paralysis, v, 80
Palate, cleft, hereditary syphilis and, i, 67
— hard, ulceration of, viii, 35
— soft, actinomycosis of, viii, 40
— — sarcoma of, iii, 194
Pallid asphyxia, ii, 198
Pallor, hemorrhagic disease and, ii, 235
Palmar reflex, ii, 113
Palmitic acid, ii, 47
Palpation, abdominal, viii, 268
— chest examination by, ix, 90
— lobar pneumonia and, ix, 147
— orthopedic examination by, vi, 8
— sacro-iliac joint, vi, 20
— spine, vi, 23
Palpebral fissure, cervical sympathetic nerves and, v, 9
Palpitation, pregnancy and, i, 30
Palsy. *See* Paralysis.
Pancreas, anatomy of, iii, 128

Pancreas, congenital syphilis and, iii, 58
— diseases of, iii, 204; viii, 331
— — diabetes mellitus, xiii, 99
— ferments present at birth, ii, 89
— newborn, iii, 128
— syphilis of, pathological evidence of, xvii, 29
— tuberculosis of, relative frequency of, ix, 231
Pancreatitis, acute, mumps causing, xiv, 147
— treatment of, xv, 334
Pandy's globulin test, xx, 98
Papilloma, laryngeal, iii, 72; ix, 82
— lingual, viii, 5
— umbilical, iii, 409
Papular acne, granulosis rubra nasi differentiated from, xvi, 278
Papular urticaria, diagnosis of, xvi, 80
— etiology of, xvi, 79
— incidence of, xvi, 78
— pathology of, xvi, 79
— prognosis of, xvi, 81
— symptoms of, xvi, 79
— treatment of, xvi, 80
Papulonecrotic tuberculid, etiology of, xvi, 238
— pathology of, xvi, 238
— symptoms of, xvi, 238
— treatment of, xvi, 239
Paracelsus, syphilis described by, xvii, 7
Paracentesis, abscess of lung and, ix, 174
Parakeratosis, xvi, 117
Paralysis, acute spinal, synonyms of, xiv, 224
— asphyxia neonatorum and, ii, 195
— Bell's, poliomyelitis differentiated from, xiv, 243
— birth, vi, 243
— — brachial, i, 124, 125
— birth injuries and, vii, 247
— brachial, cause of, v, 26
— — treatment of, v, 27
— cerebral, abdominal reflex and, v, 12
— — albuminuria and, v, 142
— — Babinski's sign in, v, 149
— — birth injuries and, v, 142, 149
— — convulsions and, v, 150
Paralysis, cerebral, decompression in, v, 146
— — definition of, v, 141
— — diphtheria causing, v, 142
— — drooling in, v, 149
— — education and, v, 152
— — encephalitis causing, v, 142
— — epidemic encephalitis causing, v, 98
— — extrapyramidal type of, v, 148
— — familial type of, v, 147
— — general discussion, v, 141
— — hemorrhage causing, v, 149
— — hydrocephalus causing, v, 150
— — infantile, iii, 223
— — infections producing, v, 142, 147
— — "infectious diarrhea" causing, v, 142
— — injury causing, v, 149
— — institutional care for, v, 147
— — operations for relief of contractures following, v, 144
— — paralysis agitans type of, v, 149
— — parity and, v, 142
— — physiotherapy for, v, 146
— — pneumonia and, v, 150
— — prenatal influences, v, 141
— — prognosis of, v, 142
— — rarity of fixed lesions of, v, 144
— — reduction of nerve supply for contractures following, v, 145
— — section of posterior roots in, v, 145
— — "sleeping sickness" causing, v, 98
— — spastic type of, v, 143
— — types of disturbances of, v, 144
— — whooping-cough causing, v, 142, 150
— cerebral spastic, vii, 246
— dental, synonyms of, xiv, 224
— Duchenne-Erb, iii, 226
— Erb's, Parrot's pseudoparalysis differentiated from, vii, 150
— facial, iii, 229
— flaccid, v, 212; vii, 240
— hereditary syphilis and, xvii, 249
— hysterical, orthopedic considerations of, vi, 254
— infantile, v, 102; vii, 240
— — acute stage of, v, 104
— — convalescent serum and, v, 105

Paralysis, infantile, convalescent stage of, v, 106
— — infective nature of, v, 103
— — orthopedic treatment of, v, 107
— — symptoms of, v, 104
— — synonyms of, xiv, 224
— ischemic, management of, vii, 159
— Klumpke, iii, 227
— lower arm, iii, 227
— lower extremity, iii, 228
— neurosyphilis clinically manifested by, xvii, 191
— newborn, diagnosis of, i, 127
— — Duchenne's, i, 124
— — Erb's, i, 124
— — facial, i, 127
— obstetrical, i, 25; iii, 225; vii, 256
— — diagnosis of, vi, 245
— — etiology of, vi, 243
— — pathology of, vi, 243
— — peripheral nerve injuries and, vi, 251
— — symptoms of, vi, 244
— — treatment of, vi, 27; vi, 245
— phrenic, iii, 230
— poliomyelitis and, vi, 219
— postdiphtheritic, xiv, 166, 173
— — delayed speech due to, v, 196
— spastic cerebral, diagnosis of, vi, 239
— — etiology of, vi, 237
— — general considerations of, vii, 246
— — pathology of, vi, 238
— — signs of, v, 143
— — symptoms of, vi, 238
— — treatment of, vi, 240
— spinal tuberculosis complicated by, vi, 89, 94
— upper arm, iii, 226
— Volkmann's, vii, 239
— — diagnosis of, vi, 212
— — etiology of, vi, 211
— — orthopedic management of, vi, 211
— — pathology of, vi, 212
— — prognosis of, vi, 213
— — symptoms of, vi, 212
— — treatment of, vi, 213
— whole arm, iii, 227
Paralysis agitans, cerebral palsy and, v, 149
Parametritis, i, 89
— milk injections in, i, 03
— symptoms of, i, 93
Paraphimosis, general considerations of, iii, 261
— symptoms of, xiv, 214
— treatment of, xv, 355; xix, 215
Paraplegia, cold abscess causing, v, 123
— Erb's spastic, neurosyphilis and, xvii, 207
— neurosyphilis causing, xvii, 195
— Pott's, vii, 122
— spastic, obstetrical history of, i, 114
— tumor of spinal cord causing, v, 127
Parapsoriasis, xvi, 133
— livedo reticularis and, xvi, 57
Parasites, animal, skin affected by, iii, 347
— — skin diseases caused by, xvi, 151
— blood, anemia secondary to, xi, 77
— — blood-count and, xi, 54
— intestinal, general considerations of, viii, 295
— — newborn and, iii, 35
— — pathogenicity of, xx, 76
— — varieties of, viii, 296, 299, 303, 305, 309
— sacrococcygeal, xv, 216
— vegetable, skin diseases due to, iii, 349
Parasitic lung infection, ix, 185
Parasitic myositis, vii, 237
Parasiticidal remedies, xvi, 349
Parasyphilitic diseases, Fournier's doctrine of, xvii, 13
Parathyroid extract, pollen fevers and, ix, 119
Parathyroid glands, disease involving, experimental hyperparathyroidism, xiii, 71
— salts and, xiii, 17
— tumors of, polyuria and, xix, 65
Parathyroid tetany, xiii, 36
Paratyphoid fever, bacteriology of, viii, 195
— complications of, viii, 197
— diagnosis of, viii, 198
— etiology of, viii, 195

Paratyphoid fever, general considerations of, viii, 195
— lesions of, viii, 196
— newborn and, iii, 29
— prognosis of, viii, 198
— symptoms of, viii, 196
— treatment of, viii, 198
— typhoid fever differentiated from, xiv, 200
Paré, syphilis described by, xvii, 7
Paregoric, acidosis in diarrheal diseases and, xiii, 33
— acute follicular tonsillitis and, ix, 55
— acute intestinal indigestion and, viii, 172
— therapeutic use of, respiratory diseases and, ix, 264
Parenchymatous cardiac edema, syphilis causing, iii, 58
Parenchymatous keratitis, late inherited syphilis and, xvii, 144, 225
Parenchymatous nephritis, xix, 78. *See also* Nephrosis
Parenchymatous tonsillitis, chronic, ix, 57
Parentage, syphilitic, fetal lesions due to, i, 64-66
Parental intoxication, prematurity and, ii, 171
Parenthood, training for, i, 3, 15
Parents, art of infant feeding and education of, xii, 144, 149
Paresis, familial syphilis and, xvii, 108
— inoculations with tertian malaria in treatment of, xvii, 267
— juvenile, cerebrospinal fluid in, xx, 104
— neurosyphilis and, xvii, 199
Paretic neurosyphilis, clinical features of, xvii, 202
Parietal bone, birth injuries of, i, 113
Parity, amount of milk affected by, ii, 143, 148
— cerebral palsies in relation to, v, 142
— head size influenced by, ii, 21
— measurements affected by, ii, 13
— milk secretion and, ii, 143, 148
— weight loss and, ii, 36
— weight variations due to, ii, 16
Paronychia, xvi, 270
— syphilitic, incidence of, xvii, 124
Parotid glands, abnormal development of, viii, 53
— anatomical and functional considerations of, viii, 52
— congenital enlargements of, iii, 187
— disturbances of secretion of, viii, 53
— epidemic infection of, iii, 198; viii, 56
— hemangioma of, viii, 53
— lymphangioma of, viii, 54
— lymphatic enlargement affecting, viii, 59
— mixed tumors of, viii, 54
— non-epidemic infection of, viii, 56
Parotitis epidemica, synonyms of, xiv, 141
Paroxysmal hemoglobinuria, xix, 68
— late inherited syphilis manifested by, xvii, 169
Paroxysmal tachycardia, electrocardiographic determination of, xviii, 181
— rheumatic infections and, xviii, 82
Parrot's nodes, xvii, 26, 137
— latent syphilis and, xvii, 227
Parrot's pseudoparalysis, vii, 141, 149
— — congenital syphilis and, iii, 44
— — differential diagnosis of, iii, 52
Partial heart-block, electrocardiographic determination of, xviii, 175
Parturition, transmission of syphilis during, xvii, 72
Passive hyperemia, xvi, 56
Passive immunity, infancy protected by, iv, 128
Passive motion, hip examined by, vi, 16
— orthopedic examination by, vi, 8
— sacro-iliac joint and, vi, 21
— spine and, vi, 23
Paste, Lassar's, formula of, xvi, 347
— mustard, counterirritant use of, respiratory diseases and, ix, 258
Pasteur treatment of rabies, xv, 13
— indications for, xiv, 329
Pasteurization, milk preparation and, xii, 16, 19; xx, 123

Pasteurized milk, infant feeding and, i, 146
Pastry, chemical content of, x, 288
Patella, congenital dislocation of, vii, 57
— postpartum fractures of, xv, 112
Patent ductus arteriosis, anatomical considerations of, xviii, 133
— clinical aspects of, xviii, 142
Patent foramen ovale, xviii, 142
— mongolism and, xiii, 157
Paternal germ, syphilis transmitted by, theory of, xvii, 64
Pathologic weight loss, limit of, ii, 34
Pathological physiology, acidosis, xiii, 25
— alkalosis and tetany, xiii, 33
— dehydration, xiii, 40
— fasting, xiii, 23
— fever, xiii, 38
— inanition, xiii, 23
— introduction, xiii, 23
Pathology, newborn, asphyxia neonatorum, ii, 192
Peas, bottle feeding supplemented by, xii, 134
Pectoral heart, iii, 104
Pectoralis major, paralysis at birth of, i, 125
Pediatrics, a progressive science, ii, 1
— early literature of, iv, 3
— education and, v, 180
— essential advantage of training in, xii, 139
— growth and development and, xii, 7
— growth of specialization in, iv, 188
— number of physicians specializing in, iv, 188
— obstetrics and, ii, 2, 121
— preventive, definition of, iv, 4
— psychiatry and, v, 160
Pediculoides ventricosus, xvi, 159
Pediculosis, iii, 348
— scalp, treatment of, xvi, 350
— types of, xvi, 152
Pediculosis capitis, diagnosis of, xvi, 155
— etiology of, xvi, 153
— pathology of, xvi, 153
— prognosis of, xvi, 156
— symptoms of, xvi, 153
Pediculosis capitis, treatment of, xvi, 156
Pediculosis corporis, scabies differentiated from, xvi, 166
— symptoms of, xvi, 156
— treatment of, xvi, 157
Pediculosis pubis, xvi, 157
Pediculus capitis, xvi, 155
Pedonephritis, Heubner's, xix, 106
Pedunculated skin flaps, scar contractures and, vi, 205
Peeling, skin, syphilitic infants and, i, 75
Peg-shaped teeth, xvii, 218
Pellagra, acrodynia differentiated from, x, 280
— diagnosis of, xiii, 132
— diet in, x, 262
— digestive disturbances in, x, 261
— etiology of, x, 255; xiii, 130
— history of, x, 254
— incidence of, x, 254
— nervous system symptoms in, x, 261
— prognosis of, xiii, 132
— scurvy differentiated from, vii, 213
— skin manifestations of, x, 257
— specific etiology of, x, 255
— symptoms of, x, 256; xiii, 132
— treatment of, x, 262; xiii, 133
Peltauf dwarfism, xiii, 152
Pelvic cellulitis, postpartum care of, i, 161
— puerperal infections and, i, 89, 93
— ulcer causing, i, 88
Pelvic tumors, i, 41-44
— abortion and, i, 45
— examination of, i, 18
Pelvis; abnormalities of, pregnancy and labor, i, 15, 18
— congenital deformities of, vii, 50
— congestion of, abortion causing, i, 6
— contracted, birth injuries due to, i, 121
— — facial paralysis and, i, 127
— — induction of premature labor and, i, 106
— examination of, i, 18, 160
— fetal head in relation to, i, 128
— flat, birth injuries due to, i, 113
— gonococcal infection of, i, 88

Pelvis, infection of, contra-indicating induction of premature labor, i. 106
— — obstetrical, milk injections in, i, 103
— newborn, vii, 9
— — proportions of, ii, 29
— pain in, prenatal care and, i, 45
— renal, capacity of, xix, 16
Pemphigus, dermatitis herpetiformis differentiated from, xvi, 105
— erythema multiforme differentiated from, xvi, 62
— impetigo contagiosa differentiated from, xvi, 207
— infection in newborn, ii, 119
— nails affected in, xvi, 269
— types of, xvi, 98
Pemphigus neonatorum, iii, 325
— diagnosis of, xvi, 213
— etiology of, xvi, 212
— prognosis of, xvi, 214
— significance of the term, xvi, 210
— symptoms of, xvi, 212
— syphilitic, xviii, 123
— syphilitic pemphigus differentiated from, iii, 52
— treatment of, xvi, 213
Pemphigus syphiliticus, i, 75
Pemphigus vulgaris, diagnosis of, xvi, 101
— etiology of, xvi, 100
— prognosis of, xvi, 102
— symptoms of, xvi, 98
— treatment of, xvi, 101
Penis, anomalies and malformations of, iii, 260
— embryology of, xix, 6
Pentose, Bial's orcin test for, xx, 9
Pepsin, ii, 87
— protein digestion by, x, 36
Peptic ulcer, chronic, viii, 110
— duodenum and, viii, 145
Peptonization, milk preparation and, xii, 22
Peptonuria, fetal death in utero and, i, 50
Percussion, abdominal, viii, 269
— chest examination by, ix, 94
— cyanosis affecting, ii, 166
— lobar pneumonia and, ix, 147
Perforation, intestinal, iii, 186
— Meckel's diverticulum and, viii, 247
— uterus, abortion and, i, 47
Perianal abscess, xv, 347
Periarthritis, shoulder, vii, 264
Pericardial effusion, physical signs of, xviii, 125, 128
— x-ray signs of, xviii, 160
Pericarditis, acute, blood-count in, xi, 47
— acute rheumatic fever complicated by, vii, 94
— bronchopneumonia and, ix, 130
— cerebrospinal meningitis complicated by, xiv, 282
— lobar pneumonia causing, ix, 159
— measles complicated by, xiv, 46
— rheumatic, diagnosis of, xviii, 199
— — pain caused by, xviii, 82
— — pathology of, xviii, 35
— — physical signs of, xviii, 124
— — significance of, xviii, 125
— scarlet fever complicated by, xiv, 21
— suppurative, incidence of, xv, 244
— tuberculous, xiv, 352
Pericardium, congenital absence of, iii, 118
— diseases of, iii, 118
— pathological physiology of, xviii, 47
— serous effusion in, iii, 119
Pericellular cirrhosis, congenital syphilis causing, iii, 58
Perineal testis, etiology of, xix, 212
Perinephritic abscess, diagnosis of, xix, 175
— etiology of, xix, 174
— incidence of, xix, 174
— pregnancy and, i, 35
— pyelitis and, xix, 174
— symptoms of, xix, 175
— treatment of, xix, 176
Perinephritis, diagnosis of, xix, 175
— etiology of, xix, 174
— incidence of, xix, 174
— pyelitis and, xix, 174
— rupture of solitary renal cyst causing, xix, 15
— symptoms of, xix, 175
— treatment of, xix, 176
Perineum, infected, local treatment of, i, 98

Perineum, lacerations of, repair, i, 97
— repaired, postpartum care of, i, 161
Periodic gain in weight and height in preschool age, iv, 25
Periodic increase in length in infancy, iv, 25
Periods, life, iv, 6
Perioral scars, latent syphilis and, xvii, 229
Periosteal sarcoma, diagnosis of, vi, 198
— frequency of, vi, 197
— pathology of, vi, 198
— prognosis of, vi, 199
— symptoms of, vi, 198
— treatment of, vi, 199
— x-ray demonstration of, vi, 198
Periosteum, bone growth influenced by, vii, 4
— syphilis of joints affecting, vi, 100
Periostitis, acute, vi, 128
— congenital syphilis and, iii, 47
— — scurvy differentiated from, xiii, 125
— gingival, viii, 13
— long bones in childhood and, hereditary syphilis and, i, 73
— proliferative, hereditary syphilis and, xvii, 246
— syphilitic, vi, 137
— — incidence of, xvii, 134
— traumatic, vi, 181
Peripheral nerves, tetany increasing excitability of, v, 130
Peripheral nerve injuries, v, 26; vi, 250
— postparalytic atrophy from, vii, 256
Peripheral neuritis, indications of, v, 216
Peripneumonia, ix, 137
Peristalsis, gastric origin of, xii, 56, 112
— hypertrophic pyloric stenosis causing increase of, viii, 116
Peristaltic waves, congenital pyloric stenosis and, iii, 141
— megacolon causing, iii, 153
Peritoneum, abscess behind, xv, 311
— diseases of, iii, 205
— puerperal infections of, i, 93
— tuberculosis of, xv, 303
Peritonitis, bacteriemia and, i, 94
— childhood, xv, 299
— congenital, iii, 206
— fetal, viii, 261
— — intestinal atresia following, iii, 146, 148
— gonococcal infection and, i, 94
— infantile, viii, 261; xv, 299
— latent, viii, 261
— newborn, xv, 298
— — acute, iii, 207
— pneumococcic, viii, 264
— — lobar pneumonia causing, ix, 160
— postpartum care of, i, 161
— puerperal infection causing, i, 88, 89
— retrodisplacements and, i, 19
— septic sore-throat causing, xiv, 311
— static, viii, 262
— streptococcic, viii, 263
— tuberculous, xv, 303
— — celiac disease differentiated from, viii, 214
— — complications of, viii, 283
— — diagnosis of, viii, 282
— — forms of, xiv, 353
— — lesions of, viii, 280
— — prognosis of, viii, 284
— — symptoms of, viii, 280
— — treatment of, viii, 282
— typhoid, perforation and, viii, 186, 190
— uterine misplacements and, i, 20, 21
Peritonsillar abscess, acute follicular tonsillitis causing, ix, 54
— diagnosis of, ix, 65
— etiology of, ix, 64
— prophylaxis of, ix, 66
— symptoms of, viii, 42; ix, 64
— treatment of, viii, 42; ix, 65; xv, 180
Peri-uterine inflammation, bacteremia and, i, 94
Perléche, diagnosis of, xvi, 344
— etiology of, xvi, 344
— symptoms of, xvi, 343
— treatment of, xvi, 344
Permanent teeth, abnormalities of, viii, 65
— caries of, viii, 66

Permanent teeth, eruption of, iv, 32; viii, 65; x, 57
— hygiene for, viii, 71
— importance of first, iv, 89
— malocclusion of, viii, 68
— syphilitic stigmata of, xvii, 215
— syphilis of, viii, 69
— trauma of, viii, 68
Permeability, intestinal wall of newborn showing increased, iii, 209
Pernicious anemia, blood-picture of, xi, 100
— breast feeding prevented by, ii, 150
— diagnosis of, xi, 94
— symptoms of, xi, 93
— treatment of, xi, 95
Peromelia, definition of, vii, 57
Peroneal reflex, tetany and, xiii, 35
Peroneal tendons, displacement of, vi, 215
Perspiration, temperature regulated by, ii, 109
Perthes' disease, diagnosis of, vi, 110; vii, 76
— etiology of, vi, 108; vii, 73
— pathology of, vii, 76
— prognosis of, vi, 110
— symptoms of, vi, 109; vii, 76
— treatment of, vi, 110; vii, 77
— tuberculosis of joints differentiated from, vi, 71, 83
— x-ray examination of, vi, 110; vii, 76
Pertossa, synonyms of, xiv, 117
Pertussis, acute bronchitis and, ix, 101
— acute infectious arthritis and, vi, 50
— atypical forms of, xiv, 123
— blood-count in, xi, 47
— bronchopneumonia following, ix, 122, 130
— character of cough of, ix, 101
— chronic bronchitis following, ix, 107
— complications of, xiv, 123
— definition of, xiv, 117
— diagnosis of, xiv, 126
— epistaxis and, ix, 18
— etiology of, iv, 140; xiv, 118
— history of, xiv, 117
— incubation of, xiv, 120
Pertussis, internal medical treatment of, xiv, 135
— pathology of, xiv, 120
— predisposition to, xiv, 119
— preventive treatment of, iv, 140; xiv, 132
— prognosis of, xiv, 129
— Public Health regulations for, xiv, 139
— rickets and, vii, 193
— specific vaccine treatment of, xiv, 137
— stages of, xiv, 121
— symptoms of, xiv, 120
— synonyms of, xiv, 117
— treatment of, xiv, 133
Perverted appetite, viii, 220
Pes calcaneovalgus, vi, 222
Pes calcaneus, vi, 221
Pes equinovalgus, vi, 222
Pes equinovarus, iii, 287; vi, 222
Pes equinus, poliomyelitis and, vi, 220
Pes planus, deformity in, vi, 257
— diagnosis of, vi, 258
— examination of, vi, 257
— symptoms of, vi, 257
— treatment of, vi, 258
Pes valgus, vi, 221
Pes varus, vi, 220
Pes varus congenitus, iii, 287
Pessary, postpartum cases and, i, 161
Petechial hemorrhages, asphyxia neonatorum and, ii, 192
— scurvy causing, vi, 188
Petechial rash, meningococcic meningitis causing, v, 89
Petit mal, epileptic significance of, v, 138
Petrolatum liquidum, laxative use of, respiratory diseases and, ix, 263
Petrosal sinuses, superior, v, 22
Petticoat, ii, 129
Peyer's patches, congenital syphilis and, iii, 59
— newborn number of, iii, 128
— typhoid pathology and, viii, 186
— Winckel's disease causing enlargement of, iii, 2
P^H, acidification of milk and, xii, 21
— blood of premature infants, ii, 166

P^H, duodenal contents in infants and, xx, 91
— gastric contents in infants and, xx, 89
— normal, mechanism for maintenance of, xx, 167
— stools in infancy and, xx, 71
P^H values, ii, 98
Phalanges, postpartum fractures of, xv, 103
Pharmaceutics, respiratory diseases and, ix, 261
Pharyngeal diphtheria, symptoms of, xiv, 163
Pharyngeal pouches, xv, 183
Pharyngeal reflex, newborn, ii, 113
Pharyngeal tonsils, anatomy of, ix, 49
— function of, ix, 50
— hypertrophy of, ix, 67
Pharyngitis, acute catarrhal, treatment of, viii, 39
— acute, diagnosis of, ix, 41
— — etiology of, ix, 40
— — symptoms of, ix, 40
— — treatment of, ix, 41
Pharynx, acute retropharyngeal abscess, xv, 178
— acute rheumatic infection of, xviii, 53, 67
— anatomy of, viii, 37; ix, 38
— congenital obstruction of, viii, 37
— diseases of, actinomycosis, viii, 40
— — acute follicular tonsillitis, viii, 46; ix, 51
— — acute pharyngitis, viii, 39; ix, 40
— — acute tonsillitis, viii, 40
— — adenoids, ix, 67
— — chronic cryptic tonsillitis, ix, 57
— — chronic hypertrophic tonsillitis, ix, 57
— — chronic lacumen tonsillitis, ix, 57
— — chronic parenchymatous tonsillitis, ix, 57
— — chronic tonsillitis, ix, 57
— — cyst of tonsil, ix, 66
— — elongation of uvula, ix, 47
— — epidemic sore-throat, ix, 44
— — glandular fever, ix, 44
— — hyperplastic tonsillitis, ix, 57
— — hypertrophic tonsillitis, ix, 57
Pharynx, diseases of, peritonsillar abscess, viii, 42; ix, 64
— — phlegmonous tonsillitis, ix, 64
— — quinsy, viii, 42; ix, 64
— — retropharyngeal abscess, viii, 43; ix, 42
— — retropharyngeal lymphadenitis, viii, 43
— — retrotonsillar abscess, ix, 64
— — rôle of lymphoid disease in, viii, 48
— — scarlatinal tonsillitis, viii, 41
— — streptococcic sore-throat, ix, 44
— — ulceromembranous tonsillitis, ix, 46
— — Vincent's angina, viii, 41; ix, 46
— foreign bodies in, viii, 37
— lymphoid disease and, viii, 48
— mumps involving, xiv, 145
— newborn, anatomy of, iii, 67
— — diverticula of, iii, 77
— — elongated uvula causing irritation of, iii, 135
— — malformations of, iii, 76
— physiology of, iii, 67; ix, 38
— tuberculosis of, xiv, 350
Phenacetin, antipyretic use of, respiratory diseases and, ix, 261
— bronchopneumonia and, ix, 135
Phenol, accidental poisoning with, viii, 311
— dermatitis caused by, xvi, 42
— urine showing presence of, ii, 106
Phenolphthalein, dermatitis caused by, xvi, 48, 53
Phenolsulphonephthalein, excretion of, kidney function determined by, xx, 20
— newborn elimination of, ii, 100
Philanthropic organizations, prenatal clinics and, i, 156
Phimosis, enuresis and, xix, 50
— general considerations of, iii, 261
— surgical considerations of, xv, 352
— symptoms of, xix, 214
— treatment of, xix, 215
Phlebitis, umbilical, iii, 406
Phlebotomy, acute decompensation and, i, 32
Phlegmasia alba dolens, i, 94
Phlegmonous tonsillitis, ix, 64

Phocomelia, definition of, vii, 55, 57
— general considerations of, iii, 283
Phosphatids, ii, 143
Phosphaturia, significance of, xx, 19
Phosphorus, accidental poisoning with, viii, 314
— amount in blood, xx, 131
— blood of newborn and, ii, 79
— prematurity demanding, ii, 186
— rickets and faulty metabolism of, iv, 122
— teeth and, viii, 64
— urine of newborn containing, ii, 106
Phosphorus poisoning, anemia caused by, xx, 50
Phosphorus salts, digestion and metabolism of, x, 41
Photochemical action, Grotthus' law of, vii, 219
— physiology of, vii, 220
Photophobia, acrodynia and, x, 278
— presence at birth, iii, 114
Phrenic paralysis, iii, 230
Phthisis, chronic, ix, 241
— fibroid pregnancy and, i, 27
Physical agents, dermatitis caused by, xvi, 33
— leukocytosis caused by, xx, 41
Physical examination, pregnant patients and, i, 160
Physician, obstetrical training of, i, 150, 151
Physiological action of food constituents, carbohydrates, xii, 46
— fats, xii, 45
— protein, xii, 49
— salts, xii, 53
— starches, xii, 49
Physiology, digestion, xii, 54
— newborn, ii, 32
— — alimentary tract, ii, 82
— — asphyxia neonatorum and, ii, 189
— — blood, ii, 63
— — chemical composition, ii, 46
— — intestines, ii, 89
— — mammary gland, ii, 141
— — muscles, ii, 109
— — nervous system, ii, 109
— — pancreas, ii, 89
— — peculiarities of, ii, 163
— — secretions, ii, 109
Physiology, newborn, skin, ii, 109
— — special senses, ii, 109
— — urinary tract, ii, 100
— — weight loss, ii, 34, 39
Physiotherapy, acute infectious arthritis and, vi, 57
— cerebral palsies and, v, 146
Pia mater, v, 111
Pica, viii, 220
Picric acid, burns and scalds and, xv, 20
— dermatitis caused by, xvi, 42
Pigeon-breast, rickets causing, vi, 182
Pigment, bile, ii, 72
Pigment spots, mongolian, iii, 345
Pigmentary diseases, general considerations of, xvi, 284
Pigmentary nevi, xvi, 5
Pigmentation, arsenical, xvi, 52
Pigmented moles, iii, 333
Pilonidal sinus, iii, 309
Pineal gland, disease involving, macrogenitosomia præcox, xiii, 74
— disorders affecting, v, 218
— tumor of, iii, 389
Pineapple juice, bottle feeding supplemented by, xii, 131
Pink disease, diagnosis of, xiii, 135
— etiology of, xiii, 134
— symptoms of, xiii, 134
— teeth and, viii, 64
— treatment of, xiii, 136
Pink lotion, formula of, xvi, 346
Pins, ii, 129
Pinta, vitiligo differentiated from, xvi, 293
Pin-worm, intestinal infestation with, viii, 296
Pirquet skin test, diagnostic value of, ix, 231
— enlarged tracheobronchial glands and, ix, 209
— joint tuberculosis and, vi, 71
— method of procedure in, ix, 287
— pleurisy with effusion and, ix, 198
— pneumonia negating, ix, 231
— technic and interpretation of, xiv, 336, 360
Pitcher douching, labor and, i, 95
Pituitary extracts, milk secretion and, ii, 142

Pituitary fossa, dystrophy from abnormalities of, v, 65
— erosion of, convulsions and, v, 137
— tumor causing distortion of, v, 118
Pituitary gland, disease involving, acromegaly, xiii, 77
— — diabetes insipidus, xiii, 85
— — dystrophia adiposogenitalis, xiii, 77
— — Fröhlich's syndrome, xiii, 77
— — recognition of, xiii, 76
— disorders of, v, 218
— growth influenced by, x, 88
— infantilism and, xiii, 147
Pituitary infantilism, x, 142
Pituitrin, abortion and, i, 47
— abruptio placentæ and, i, 56
— asphyxia neonatorum and, ii, 196
— cyanosis caused by use of, ii, 205
— danger to fetus in use of, ii, 123, 205
— intracerebral hemorrhage and, v, 47
— lobar pneumonia and, ix, 165
— sapremia and, i, 93
Pityriasis, pediculosis capitis differentiated from, xvi, 155
Pityriasis capitis, diagnosis of, xvi, 135
— etiology of, xvi, 134
— symptoms of, xvi, 134
— treatment of, xvi, 135
Pityriasis rosea, diagnosis of, xvi, 139
— eczema seborrheicum differentiated from, xvi, 136
— etiology of, xvi, 139
— incidence of, xvi, 137
— pathology of, xvi, 139
— prognosis of, xvi, 140
— psoriasis differentiated from, xvi, 128
— symptoms of, xvi, 138
— treatment of, xvi, 140
Pityriasis rubra pilaris, diagnosis of, xvi, 147
— etiology of, xvi, 147
— nails affected in, xvi, 269
— pathology of, xvi, 147
— prognosis of, xvi, 148
— symptoms of, xvi, 145
— treatment of, xvi, 147
Pityriasis simplex, alopecia due to, xvi, 256
Pityriasis versicolor, diagnosis of, xvi, 196
— etiology of, xvi, 195
— prognosis of, xvi, 196
— symptoms of, xvi, 195
— treatment of, xvi, 196
Placenta, asphyxia neonatorum and circulation of, ii, 191
— Credé technic in expressing, infections due to, i, 91, 94, 97
— detachment of, asphyxia neonatorum and, ii, 192
— fetal maldevelopment from infarcts of, v, 141
— hemorrhages of, i, 51-61
— — fetal death due to, i, 9
— icterus and iron content of, ii, 214
— infection of, early rupture of the membranes causing, i, 96
— leprosy in, iii, 64
— mammary gland and, ii, 141
— manual removal of, sepsis and, i, 91, 97
— normal, illus., i, 70
— pathological evidence of syphilis of, xvii, 21
— position of, abortions and, i, 45
— premature separation of, illus., i, 52-54, 57-59
— — fetal death and, i, 48
— — hemorrhage and, i, 51-61
— — maternal death due to, i, 11
— puerperal infections and, i, 88, 89, 91, 94
— respiratory impulse in newborn stimulated by separation of, ii, 52
— syphilis transmitted through, xvii, 70
— syphilitic, i, 68-69; iii, 50
— — fetal infection by, i, 66
— — laboratory examination of, i, 68
— — newborn and, i, 78
— thrombophlebitis and, i, 94
— thrombosis, death in utero and, i, 107
— tuberculosis and, i, 26; iii, 60
Placenta marginata, abruptio placentæ and, i, 52

Placenta prævia, bag technic in, i, 109
— blood transfusion in, i, 104
— cyanosis caused by, ii, 205
— differential diagnosis and, i, 55
— fetal death and, i, 48
— hemorrhage and, i, 12, 51, 91
— prenatal care and, i, 12, 56-61
— shock and, i, 133
— tamponage in, i, 110
— treatment of, i, 58
Placental extracts, milk secretion and, ii, 142
Placental lobules, removal of, i, 92
Plague, bubonic, newborn and, iii, 30
Plantar reflex, ii, 113, 115
— encephalitis showing, v, 101
Plants, dermatitis caused by, xvi, 42
Plasma, blood, functions of, xi, 7
Plasma calcium, milk calcium and, ii, 143
Plasmodium malariæ, pathogenicity of, xiv, 210
Plaster-of-Paris, ankle tuberculosis and, vi, 78
— bandages, vi, 26
— braces measured with aid of, vi, 46
— Calot jacket of, vi, 41
— orthopedic use of, vi, 26
— pressure symptoms from, vi, 45
— reënforcements of, vi, 45
— regional application of, vi, 27
— — ankle, vi, 27
— — elbow fixation by, vi, 43
— — femur, vi, 150
— — flat-foot and, vi, 260
— — forearm fractures and, vi, 154
— — knee, vi, 29
— — sacro-iliac joint, vi, 37
— — shoulder, vi, 43
— scoliasis and, vi, 268
— types of jackets made from, vi, 40
Plastic bronchitis, ix, 106
Plastic pneumonia, ix, 137
Platelets, blood, age and possible variation in number of, xi, 38
— — clotting and, ii, 233
— — count of, xi, 28
— — functions of, xi, 6
— — morphology, origin and significance of, xi, 21
— — number of, xx, 35
Platelets, blood, purpura and, xi, 189
Plaut's angina, xv, 180
Play, hygiene and, iv, 85
— preventive pediatrics and, iv, 70
Plenck, syphilis described by, xvii, 8
Pleocytosis, significance of, v, 15
Pleura, anatomy of, ix, 192
— diseases of, iii, 93
— — acute pleurisy, ix, 192
— — dry pleurisy, ix, 192
— — empyema, ix, 199
— — fibrinous pleurisy, ix, 192
— — pleurisy, ix, 192
— — pleurisy with effusion, ix, 195
— — pleurisy with purulent effusion, ix, 199
— — pyothorax, ix, 199
— — tuberculous pleurisy, ix, 243
Pleural effusion, rheumatic fever complicated by, xviii, 128
— treatment of, xviii, 222
Pleurisy, ix, 192
— acute, character of cough of, ix, 100
— — diagnosis of, ix, 194
— — etiology of, ix, 192
— — pathology of, ix, 193
— — physical signs of, ix, 194
— — symptoms of, ix, 193
— — treatment of, ix, 194
— acute rheumatic fever complicated by, xiv, 394
— dry, ix, 192
— effusive, diagnosis of, ix, 197
— — etiology of, ix, 195
— — lobar pneumonia differentiated from, ix, 155
— — pathology of, ix, 195
— — physical signs of, ix, 196
— — symptoms of, ix, 195
— — treatment of, ix, 198
— fibrinous, ix, 192
— pulmonary tuberculosis differentiated from, xiv, 352
— purulent effusive, ix, 199
— rheumatic, pathology of, xviii, 39
— scarlet fever complicated by, xiv, 22
— tuberculous, incidence of, ix, 243
— — prognosis of, ix, 244
— — symptoms of, ix, 243
Pleuritis, ix, 192

Pleuritis, purulent, pericarditis following, iii, 119
Pleuropneumonia, ix, 137
Plumbism, prematurity caused by, ii, 163
— size of child and, ii, 14
Plus ratio of respiration, ii, 52
Pneumococcic peritonitis, general considerations of, viii, 264
— lobar pneumonia causing, ix, 160
Pneumococcic septicemia, lobar pneumonia causing, ix, 160
Pneumococcic serum, i, 99
Pneumococcus, acute infectious arthritis and, vi, 50
— examination of sputum for, xx, 85
— infection of fetus by, iii, 10
— types of, ix, 138
Pneumococcus meningitis, cerebrospinal fluid in, xx, 109
Pneumonia, acute, ix, 137
— acute bronchitis and, ix, 101
— acute infectious arthritis and, vi, 50
— acute rheumatic fever complicated by, xiv, 394
— alopecia due to, xvi, 256
— anemia caused by, xx, 50
— aspiration, ii, 195; ix, 176
— bacteriology of, xx, 85
— blood-count in, xi, 47, 48
— breast feeding prevented by, ii, 150
— bronchial, acute, ix, 121
— — acute rhinitis causing, ix, 6
— — leukocytosis in, xx, 48
— — thrombophlebitis causing, i, 94
— catarrhal, ix, 121
— central, ix, 148
— cerebrospinal meningitis complicated by, xiv, 282, 291
— cerebrospinal meningitis differentiated from, xiv, 281
— character of cough of, ix, 100
— chronic, diagnosis of, ix, 170
— — empyema differentiated from, ix, 200
— — etiology of, ix, 168
— — pathology of, ix, 169
— — symptoms of, ix, 169
— — treatment of, ix, 170
— chronic interstitial, ix, 168
Pneumonia, chronic tuberculous, diagnosis of, ix, 241
— convulsions in, v, 78
— croupous, ix, 137
— deaths during first 14 days, ii, 5
— deglutition, ix, 176
— epistaxis and, ix, 18
— fetal death and, i, 48
— fever associated with, xiii, 39
— fibrinous, ix, 137
— foreign bodies causing, ix, 191
— hemorrhagic, iii, 81
— hydrocephalus following, v 150
— hypostatic, etiology of, ix, 171
— — newborn, iii, 84
— — pathology of, ix, 171
— — treatment of, ix, 172
— icterus index in, xx, 40
— incidence of types of, xx, 86
— infant mortality and, iv, 111
— insufflation, diagnosis of, ix, 179
— — endogenous, ix, 176
— — etiology of, ix, 176
— — exogenous, ix, 177
— — pathology of, ix, 178
— — prophylaxis of, ix, 180
— — symptoms of, ix, 178
— — treatment of, ix, 180
— intra-uterine, iii, 83
— lactic acid acidosis in, xx, 172
— lobar, abdominal distention in, ix, 165
— — abdominal type of, ix, 152
— — abortive type of, ix, 149
— — acute appendicitis differentiated from, viii, 253
— — associated conditions in, ix, 158
— — bacteriology of, ix, 137
— — blood picture in, ix, 145
— — bowel care in, ix, 163
— — bronchopneumonia simulating, ix, 123
— — cerebral type of, ix, 150
— — character of cough in, ix, 144
— — chicken blood therapy in, ix, 167
— — clinical picture of, ix, 140
— — clinical types of, ix, 149
— — complications of, ix, 159
— — concealed type of, ix, 151
— — congestion stage of, ix, 138
— — counterirritation in, ix, 163

Pneumonia, lobar, course of, ix, 152
— — diagnosis of, ix, 153
— — diathermy in, ix, 167
— — diet in, ix, 164
— — empyema differentiated from, ix, 200
— — etiology of, ix, 140
— — gastro-intestinal disturbances in, ix, 145
— — gray hepatization stage of, ix, 139
— — heart complications in, xviii, 190
— — heart stimulation in, ix, 166
— — herpes simplex and, xvi, 87
— — hydrotherapy in, ix, 164
— — inhalations in, ix, 166
— — leukocytosis in, xx, 47
— — mercurochrome in, ix, 167
— — migratory type of, ix, 149
— — Morgan's prognosis of, ix, 161
— — nervous disturbances in, ix, 146
— — oxygen in, ix, 165
— — pain in, ix, 144
— — pathology of, ix, 138
— — physical signs in, ix, 146
— — primary nature of, ix, 140
— — prognosis of, ix, 152
— — prolonged type of, ix, 149
— — pulmonary tuberculosis differentiated from, xiv, 352
— — pulse in, ix, 142
— — red hepatization stage of, ix, 139
— — resolution of, ix, 139
— — respiration in, ix, 143
— — rheumatic fever complicated by, xviii, 39
— — rheumatic infections and, xviii, 79
— — scalene sign in, ix, 148
— — serum treatment of, ix, 167
— — short duration type of, ix, 149
— — skin symptoms in, ix, 144
— — stages of, ix, 138
— — symptoms of, ix, 140
— — — unfavorable, ix, 148
— — temperature in, ix, 141
— — treatment of, ix, 160
— — typical signs of, ix, 153
— — urine in, ix, 145
— lobular, ix, 121
— massive, ix, 137
Pneumonia, nasal infections followed by, iii, 77
— nephrosis and, xix, 80
— newborn, differential diagnosis of, iii, 86
— peri, ix, 137
— peritonsillar abscess causing, ix, 65
— plastic, ix, 137
— pleural, ix, 137
— postoperative, ix, 176
— postpartum, i, 2
— sputum in, characteristic appearance of, xx, 84
— sthenic, ix, 137
— tuberculin test negatived by, ix, 231
— typhoid fever complicated by, viii, 190, 191
— typing of, method of, xx, 85
Pneumonia alba, atelectasis in newborn caused by, iii, 88
Pneumonia neonatorum, iii, 83
Pneumothorax, aspiration of pleurisy and, ix, 199
— empyema and, ix, 205
— treatment of, xv, 219
Pocken, synonyms of, xiv, 80
Poikilocytosis, definition of, xi, 15
Poison ivy, dermatitis caused by, xvi, 43
Poison oak, dermatitis caused by, xvi, 46
Poison sumach, dermatitis caused by, xvi, 46
Poisoning, accidental, acids, viii, 311
— — alcohol, viii, 311
— — alkalies, viii, 310
— — arsenic, viii, 311
— — aspidium, viii, 312
— — atropin, viii, 312
— — camphor, viii, 312
— — chenopodium, viii, 312
— — formaldehyde, viii, 313
— — lead, viii, 313
— — mercury, viii, 313
— — opium, viii, 313
— — phosphorus, viii, 314
— — santonin, viii, 314
— — silver nitrate, viii, 314
— — turpentine, viii, 314
— carbon monoxid, alkalosis caused by, xx, 175

Poisoning, chemical, anemia caused by, xi, 80; xx, 50
— — blood-count and, xi, 54
— food, alimentary allergy, viii, 316
— — botulism, viii, 315
— — milk-sickness, viii, 320
— lead, convulsions from, v, 136
Polioencephalitis, acute, vomiting and, viii, 95
— cerebrospinal fluid in, xx, 115
Poliomyelitis, abortive form of, xiv, 240
— acute anterior, v, 102
— — acute syphilitic epiphysitis differentiated from, vii, 150
— — cerebrospinal fluid in, xx, 115
— — clinical course of, vi, 218
— — diagnosis of, vii, 243
— — etiology of, vi, 218; vii, 241
— — hip-joint dislocation following, vii, 60
— — infective nature of, v, 103
— — leukocytosis in, xx, 44
— — Little's disease differentiated from, vi, 239
— — onset of, vii, 240
— — operative measures for correction of deformity, vi, 228
— — orthopedic management of, vi, 218
— — pathology of, vi, 218; vii, 241
— — prevention of, iv, 141
— — prognosis of, vi, 225
— — progressive muscular atrophy differentiated from, v, 69; vi, 247, 249
— — reflexes in, v, 104
— — scoliosis and, vi, 263
— — scurvy differentiated from, vii, 213
— — stages of, v, 104
— — symptoms of, v, 104; vi, 218; vii, 241
— — treatment of, v, 105; vi, 226; vii, 244
— acute meningitic, cerebrospinal meningitis differentiated from, xiv, 281
— anterior, newborn and, iii, 31
— — Volkmann's paralysis differentiated from, vi, 212
Poliomyelitis, bacteriology of, xiv, 231
— carriers of, xiv, 230
— classification of forms of, xiv, 236
— definition of, xiv, 224
— diagnosis of, xiv, 243
— epidemic encephalitis differentiated from, xiv, 261
— epidemiology of, xiv, 226
— etiology of, xiv, 230
— forms of, xiv, 236
— geographic distribution of, xiv, 227
— history of, xiv, 224
— incubation period of, xiv, 237
— non-paralytic form of, xiv, 240
— onset of, xiv, 225
— pathology of, xiv, 234
— portals and vehicles of infection in, xiv, 233
— prevention of, xiv, 246
— prognosis of, xiv, 244
— Public Health regulations for, xiv, 252
— stages of, xiv, 237
— — paralytic, xiv, 238
— — preparalytic, xiv, 237
— symptoms of, xiv, 237
— synonyms, xiv, 224
— transmission of, xiv, 228
— treatment of, xiv, 247
— virus of, xiv, 232
Poliomyelitis anterior acuta, synonyms of, xiv, 224
Pollakiuria, enuresis and, xix, 49, 51, 67
— incidence of, xix, 66
Pollen extract, pollen fevers and, ix, 119
Pollen fevers, classification of, ix, 117
— complications of, ix, 118
— diagnosis of, ix, 118
— etiology of, ix, 117
— prophylaxis of, ix, 120
— susceptibility and, viii, 317
— symptoms of, ix, 118
— treatment of, ix, 119
Pollinosis, ix, 117
Polyarthritis, acute rheumatic, convalescent care of, xviii, 58
— — symptoms and signs of, xviii, 52
— — treatment of, xviii, 55

Polyarthritis, diagnosis of, vi, 104
— syphilitic, manifestations of, vi, 100
Polyarthritis rheumatica, synonyms of, xiv, 388
Polychromatophilia, definition of, xi, 15
Polycoria, iii, 362
Polycystic kidneys, clinical signs of, xx, 155
— general considerations of, xv, 364
Polycythemia, absolute, functional, xi, 216
— — primary, xi, 218
— blood changes in, xx, 54
— congenital cyanosis and, ii, 204
— functional absolute, xi, 216
— primary absolute, blood-count in, xi, 219, 220
— — case history of, xi, 218
— — etiology of, xi, 218
— — treatment of, xi, 220
— relative, xi, 215
Polycythemia vera, discovery of, xi, 5
Polydactylism, general considerations of, iii, 285
— heredity and, iv, 8, 11
— mendelian aspects of, v, 61
— types of, vii, 56, 58
Polygnathia, iii, 131
Polyhydramnios, induction of labor and, i, 108
Polymorphonuclear leukocytes, age and possible variation in number of, xi, 38
Polymorphonuclear neutrophils, morphology of, xi, 16
Polymyositis, hemorrhagic, vii, 234
Polyneuritic syndrome, x, 276
Polyneuritis, endemic, x, 264
— erythredema, diagnosis of, xiii, 135
— — etiology of, xiii, 134
— — symptoms of, xiii, 134
— — treatment of, xiii, 136
— etiology of, xiii, 133
— symptoms of, xiii, 133
— treatment of, xiii, 134
— vitamin B and, x, 23
Polypi, nasal, hemorrhage caused by, ix, 18
— rectal, viii, 294
Polypi, rectal, ileus caused by, iii, 196
— — incidence of, xv, 34
— treatment of, xv, 345
— umbilical, iii, 400
Polyuria, diagnosis of, xix, 64
— symptoms associated with, xix, 64, 65
Polyvalent antistreptococcic serum, i, 99, 101, 103
Pompholyx, diagnosis of, xvi, 94
— etiology of, xvi, 93
— pathology of, xvi, 93
— prognosis of, xvi, 94
— symptoms of, xvi, 93
— treatment of, xvi, 94
Pons, disorders of, v, 217
Porencephalus, iii, 213, 250
Porpoise's milk, chemical composition of, xii, 10
Portable metabolism apparatus, xiii, 1, 8
Porthesia chryssorhœa, xvi, 161
Positive nitrogen balance, xiii, 15
Postabsorptive state, definition of, xiii, 13
Postdiphtheritic paralysis, v, 80
— delayed speech due to, v, 196
— incidence of, xiv, 166
Postencephalic states, v, 12
Posterior nerve roots, pathology of, v, 215
— section of, v, 145
Posterior occipital presentation, molding from, ii, 26
Postgraduate obstetrics, need for, i, 150
Postmortems, puerperal infections originating at, i, 86
Postnasal catarrh, ix, 9
Postnatal death, i, 9
Postnatal examination of baby, i, 160
Postnatal mortality, familial syphilis and, xvii, 103
Postnatal syphilis, fetal death due to, i, 63
Postoperative care, xv, 31
Postoperative pneumonia, ix, 176
Postparalytic atrophy, peripheral nerve injury causing, vii, 256
Postpartum cases, care of, i, 160
— examination of, i, 160

Postpartum cases, gonococcal infection in, i, 88
— hygiene of, i, 95
— nursing in, i, 140
— pyelitis and, i, 35
— tuberculosis in, i, 27
— uterine infections in, i, 92
Postpartum fractures, clavicle, xv, 82
— compound, xv, 116
— elbow, xv, 87, 91
— emergency treatment of, xv, 117
— femur, xv, 103, 106, 109
— forearm, xv, 95
— humerus, xv, 84
— metacarpal bones, xv, 102
— patella, xv, 112
— phalanges, xv, 103
— principles of treatment of, xv, 81
— scapula, xv, 84
— tibia and fibula, xv, 112
— ulna, xv, 94
Postpartum hemorrhage, Credé technic and, i, 97
— myomata with, maternal death from, i, 11
— shock and, i, 130
Postpartum pneumonia, i, 2
Postscarlatinal nephritis, xiv, 20
Postural albuminuria, xx, 7
Posture, albuminuria and, xix, 61
— congenital defects in, iv, 35
— defective, orthopedic affections caused by, vi, 49
— determination of, vi, 6
— faulty, vii, 269
— — correction of, x, 196
— gastric digestion and, xii, 55
— Harvard studies on, vii, 266
— health and, iv, 35
— heart murmurs affected by, xviii, 102
— importance of, iv, 32
— inanition and, x, 217
— malnutrition and, iv, 150
— newborn, ii, 10
— normal, x, 102
— nutrition and, x, 105
— one to six years, x, 95
— preventive pediatrics and, iv, 14
— puberty and fixation of faults of, iv, 38
Posture, pubescent, iv, 32
— rest periods and, iv, 37
— rickets causing defects in, iv, 35
— school age, iv, 32
— standards of, iv, 33
— uterine displacements and, x, 217
— visceral ptosis and, viii, 270
— weight-bearing line and, vi, 6
Potassium bromid, convulsions controlled by, iii, 248
Potassium chlorate poisoning, anemia caused by, xi, 82
Potassium citrate, pyelitis of pregnancy treated with, i, 36
— therapeutic use of, respiratory diseases and, ix, 261
Potassium iodid, exophthalmic goiter and, xiii, 49
— simple goiter prophylaxis and, xiii, 46
— syphilis of bones and joints and, vi, 102
Potassium permanganate, gonorrhea of pregnancy treated with, i, 61, 62
Potato, bottle feeding supplemented by, xii, 134
— diet of pregnancy and, i, 165
Pot liquor, scurvy treated by use of, x, 227
Pott's disease, complications of, vi, 88; vii, 123
— diagnosis of, vi, 91; vii, 122
— dwarfism associated with, xiii, 152
— etiology of, vii, 119
— hip-joint disease differentiated from, vii, 127
— history of, vii, 118
— pathology of, vii, 119
— prognosis of, vi, 92; vii, 123
— rickets differentiated from, vii, 192
— symptoms of, vi, 85; vii, 120
— treatment of, vi, 92; vii, 123
— X-ray examination in, vi, 90
Pott's fracture, infancy and, xv, 116
Pott's paraplegia, vii, 122
Poultices, counterirritant use of, respiratory diseases and, ix, 257
— flaxseed, nausea of pregnancy and, i, 25
Powder marks, removal of, xvi, 286

Prematurity, incubators and, ii, 179
— infant mortality and, iv, 111
— initial weight loss and, ii, 169
— labor and, cardiac cases and, i, 33
— — conservatism and, i, 19
— — death in utero prevented by, i, 49
— — induction of, i, 106-110
— — prenatal care preventing, i, 12, 15, 149
— — syphilis causing, i, 79
— lactose and, ii, 168
— malnutrition caused by, iv, 151
— management of, ii, 176
— meconium and, ii, 168
— medicinal treatment of, ii, 186
— megacephalus in, ii, 164
— mortality of, ii, 3, 6, 174, 176; iv, 107
— nervous system and, ii, 168
— ninth month, ii, 165
— nursing care, ii, 180
— overfeeding in, danger of, ii, 184
— prenatal care reducing, i, 7, 44, 150
— prognosis and, ii, 170, 174
— prophylactic care and, ii, 176
— ptyalin and, ii, 168
— respiratory signs of, ii, 165
— rickets and, ii, 172
— sepsis and, ii, 171
— sepsis neonatorum and, iii, 14
— seventh month, ii, 164
— spasmophilia and, ii, 172
— symptoms of disease in, ii, 172
— syphilis and, i, 79; ii, 171
— syphilis causing, iii, 41
— temperature and, ii, 168
— tenth month, ii, 165
— thermolability and, ii, 169, 178
— toxemias of pregnancy causing, i, 7
— treatment of, ii, 186
— tuberculosis and, ii, 171
— underfeeding and, iv, 45
— urinary tract and, ii, 168
— weight gain, elements affecting, ii, 42
— weight loss, initial, ii, 169
Prenatal care, i, 1-14
— abortions and, i, 7, 44-48
— dental hygiene and, viii, 70
— diet of pregnancy and, i, 22-25
— essentials of, i, 15-62
Prenatal care, examination of patient and, i, 17-22
— exhibits and, public health, i, 157
— medical complications of pregnancy and, i, 25-62
— organized, i, 12-14
— prematurity and, i, 7
— Public Health and, i, 149-175
— — directions for mothers, i, 161
— — infant care, i, 173
— — midwife and, i, 151, 154
— — New York City plan for, i, 155
— purposes of, i, 15
— sepsis and, i, 5
— syphilitic infant deaths reduced by, i, 64, 82
Prenatal clinics, i, 10-14
— advantages of, ii, 2
— child hygiene and, iv, 176, 179
— doctors' duties at, i, 160
— maternity protection and, i, 156
— Wassermann reaction reports in, i, 77
Prenatal death, syphilis causing, iv, 145
Prenatal deformities, orthopedic consideration of, vi, 273
Prenatal growth, x, 42, 46
Prenatal hygiene, i, 10
Prenatal nutrition, x, 42, 46
Preoperative care, xv, 28
Prepatellar bursitis, orthopedic management of, vi, 217
Prepuce, adherent, iii, 260
— congenital cysts of, iii, 276
Presacral tumors, surgery of, xv, 216
Preschool age, adenoids and tonsils during, iv, 157, 158, 159
— anatomy during, x, 51
— average weight for height table in, iv, 20
— carious teeth during, iv, 160
— clinics for preschool children, iv, 179
— clothing during, iv, 87
— dental hygiene and, viii, 70
— development record for, iv, 193, 194, 195, 196
— diet during, iv, 56
— education and, iv, 92

Preschool age, environmental causes of malnutrition during, iv, 160
— exercise and play during, iv, 85
— food habits during, iv, 75
— growth during, iv, 19
— habit formation in, iv, 71
— length of, x, 50
— malnutrition in, iv, 154
— measles and, iv, 137
— mental measurements at, iv, 80
— morbidity in, iv, 120
— mortality and, iv, 118, 119
— periodic gain in weight and height during, iv, 25
— prevention of diphtheria during, iv, 132
— rest and sleep during, iv, 83
— teeth at, iv, 32
— vacations during, iv, 86
— weight and height averages during, iv, 20
— weight, height, age table for, iv, 21
Pressure, abnormal, birth injuries and, i, 112
— cranial, death due to, i, 117
— dermatitis caused by, xvi, 33
— intra-abdominal, i, 131
— intracranial, i, 113
— — blood injections in, i, 115
— — facial paralysis and, i, 128
Prevention, diphtheria at preschool age, iv, 132
— diphtheria in infancy, iv, 132
— prenatal care and, i, 1, 9, 10, 15-62
Preventive pediatrics, anterior poliomyelitis and, iv, 141
— breast feeding and, iv, 41
— broken compensation and, iv, 127
— cardiac disease and, iv, 126
— chickenpox and, iv, 138
— chief points of attack of, iv, 13
— child hygiene movement and, iv, 169
— communicable diseases and, iv, 128
— development charts and, iv, 193
— diet and, iv, 39
— diphtheria and, iv, 132
— Duke's disease and, iv, 138
— endocarditis and, iv, 126
— exanthem subitum and, iv, 138
— family physician and, iv, 5
Preventive pediatrics, field of, iv, 3
— food habits and, iv, 163
— fourth disease and, iv, 138
— gastro-intestinal infections and, iv, 146
— growth of child and, iv, 14
— heredity and, iv, 8
— hygiene and, iv, 83
— infant welfare and, iv, 177
— malnutrition and, iv, 149
— measles and, iv, 136
— mental growth and, iv, 65
— methods used in, iv, 169
— mumps and, iv, 141
— nutrition and, iv, 39
— periodical examinations and, iv, 190
— pertussis and, iv, 140
— physical development and, iv, 14
— poliomyelitis and, iv, 141
— posture and, iv, 14
— practical considerations of, iv, 184
— preschool children and, iv, 179
— psychological factors in, iv, 185, 188
— public demand responsible for, iv, 7
— record forms, iv, 191
— rickets and, iv, 122
— rubella and, iv, 138
— scarlet fever and, iv, 134
— Schick test and, iv, 133
— scurvy and, iv, 124
— simple goitre and, iv, 125
— smallpox and, iv, 139
— specific diseases and, iv, 122
— syphilis and, iv, 145
— tuberculosis and, iv, 142
— yearly examination form, iv, 197
Prickly heat, iii, 349; xvi, 277
Primary absolute polycythemia, blood-count in, xi, 219, 220
— case history of, xi, 218
— etiology of, xi, 218
— treatment of, xi, 220
Primary anemias, aplastic anemia, xi, 87
— blood changes in, xx, 49
— chlorosis, xi, 85
— pernicious anemia, xi, 93
— sickle-cell anemia, xi, 95
— *See also* Idiopathic anemia.
Primary myositis, vii, 234

Prematurity, incubators and, ii, 179
— infant mortality and, iv, 111
— initial weight loss and, ii, 169
— labor and, cardiac cases and, i, 33
— — conservatism and, i, 19
— — death in utero prevented by, i, 49
— — induction of, i, 106-110
— — prenatal care preventing, i, 12, 15, 149
— — syphilis causing, i, 79
— lactose and, ii, 168
— malnutrition caused by, iv, 151
— management of, ii, 176
— meconium and, ii, 168
— medicinal treatment of, ii, 186
— megacephalus in, ii, 164
— mortality of, ii, 3, 6, 174, 176; iv, 107
— nervous system and, ii, 168
— ninth month, ii, 165
— nursing care, ii, 180
— overfeeding in, danger of, ii, 184
— prenatal care reducing, i, 7, 44, 150
— prognosis and, ii, 170, 174
— prophylactic care and, ii, 176
— ptyalin and, ii, 168
— respiratory signs of, ii, 165
— rickets and, ii, 172
— sepsis and, ii, 171
— sepsis neonatorum and, iii, 14
— seventh month, ii, 164
— spasmophilia and, ii, 172
— symptoms of disease in, ii, 172
— syphilis and, i, 79; ii, 171
— syphilis causing, iii, 41
— temperature and, ii, 168
— tenth month, ii, 165
— thermolability and, ii, 169, 178
— toxemias of pregnancy causing, i, 7
— treatment of, ii, 186
— tuberculosis and, ii, 171
— underfeeding and, iv, 45
— urinary tract and, ii, 168
— weight gain, elements affecting, ii, 42
— weight loss, initial, ii, 169
Prenatal care, i, 1-14
— abortions and, i, 7, 44-48
— dental hygiene and, viii, 70
— diet of pregnancy and, i, 22-25
— essentials of, i, 15-62
Prenatal care, examination of patient and, i, 17-22
— exhibits and, public health, i, 157
— medical complications of pregnancy and, i, 25-62
— organized, i, 12-14
— prematurity and, i, 7
— Public Health and, i, 149-175
— — directions for mothers, i, 161
— — infant care, i, 173
— — midwife and, i, 151, 154
— — New York City plan for, i, 155
— purposes of, i, 15
— sepsis and, i, 5
— syphilitic infant deaths reduced by, i, 64, 82
Prenatal clinics, i, 10-14
— advantages of, ii, 2
— child hygiene and, iv, 176, 179
— doctors' duties at, i, 160
— maternity protection and, i, 156
— Wassermann reaction reports in, i, 77
Prenatal death, syphilis causing, iv, 145
Prenatal deformities, orthopedic consideration of, vi, 273
Prenatal growth, x, 42, 46
Prenatal hygiene, i, 10
Prenatal nutrition, x, 42, 46
Preoperative care, xv, 28
Prepatellar bursitis, orthopedic management of, vi, 217
Prepuce, adherent, iii, 260
— congenital cysts of, iii, 276
Presacral tumors, surgery of, xv, 216
Preschool age, adenoids and tonsils during, iv, 157, 158, 159
— anatomy during, x, 51
— average weight for height table in, iv, 20
— carious teeth during, iv, 160
— clinics for preschool children, iv, 179
— clothing during, iv, 87
— dental hygiene and, viii, 70
— development record for, iv, 193, 194, 195, 196
— diet during, iv, 56
— education and, iv, 92

Preschool age, environmental causes of malnutrition during, iv, 160
— exercise and play during, iv, 85
— food habits during, iv, 75
— growth during, iv, 19
— habit formation in, iv, 71
— length of, x, 50
— malnutrition in, iv, 154
— measles and, iv, 137
— mental measurements at, iv, 80
— morbidity in, iv, 120
— mortality and, iv, 118, 119
— periodic gain in weight and height during, iv, 25
— prevention of diphtheria during, iv, 132
— rest and sleep during, iv, 83
— teeth at, iv, 32
— vacations during, iv, 86
— weight and height averages during, iv, 20
— weight, height, age table for, iv, 21
Pressure, abnormal, birth injuries and, i, 112
— cranial, death due to, i, 117
— dermatitis caused by, xvi, 33
— intra-abdominal, i, 131
— intracranial, i, 113
— — blood injections in, i, 115
— — facial paralysis and, i, 128
Prevention, diphtheria at preschool age, iv, 132
— diphtheria in infancy, iv, 132
— prenatal care and, i, 1, 9, 10, 15-62
Preventive pediatrics, anterior poliomyelitis and, iv, 141
— breast feeding and, iv, 41
— broken compensation and, iv, 127
— cardiac disease and, iv, 126
— chickenpox and, iv, 138
— chief points of attack of, iv, 13
— child hygiene movement and, iv, 169
— communicable diseases and, iv, 128
— development charts and, iv, 193
— diet and, iv, 39
— diphtheria and, iv, 132
— Duke's disease and, iv, 138
— endocarditis and, iv, 126
— exanthem subitum and, iv, 138
— family physician and, iv, 5
Preventive pediatrics, field of, iv, 3
— food habits and, iv, 163
— fourth disease and, iv, 138
— gastro-intestinal infections and, iv, 146
— growth of child and, iv, 14
— heredity and, iv, 8
— hygiene and, iv, 83
— infant welfare and, iv, 177
— malnutrition and, iv, 149
— measles and, iv, 136
— mental growth and, iv, 65
— methods used in, iv, 169
— mumps and, iv, 141
— nutrition and, iv, 39
— periodical examinations and, iv, 190
— pertussis and, iv, 140
— physical development and, iv, 14
— poliomyelitis and, iv, 141
— posture and, iv, 14
— practical considerations of, iv, 184
— preschool children and, iv, 179
— psychological factors in, iv, 185, 188
— public demand responsible for, iv, 7
— record forms, iv, 191
— rickets and, iv, 122
— rubella and, iv, 138
— scarlet fever and, iv, 134
— Schick test and, iv, 133
— scurvy and, iv, 124
— simple goitre and, iv, 125
— smallpox and, iv, 139
— specific diseases and, iv, 122
— syphilis and, iv, 145
— tuberculosis and, iv, 142
— yearly examination form, iv, 197
Prickly heat, iii, 349; xvi, 277
Primary absolute polycythemia, blood-count in, xi, 219, 220
— case history of, xi, 218
— etiology of, xi, 218
— treatment of, xi, 220
Primary anemias, aplastic anemia, xi, 87
— blood changes in, xx, 49
— chlorosis, xi, 85
— pernicious anemia, xi, 93
— sickle-cell anemia, xi, 95
— *See also* Idiopathic anemia.
Primary myositis, vii, 234

Primary purpura, symptoms of, xvi, 67
Primrose, xvi, 46
Primary splenic anemia, treatment of, xv, 335
Primipara, induction of labor in, i, 109
Primitive blasts, characteristics of, xi, 12
— significance of, xi, 15
Primordial dwarfism, xiii, 152
Primula abconica, xvi, 46
P-R interval, ii, 62
— definition of, xviii, 44, 166
Proctitis, etiology of, viii, 291
— gonorrheal, treatment of, viii, 292
Proctoclysis, dehydration and, xiii, 42
— technic of, viii, 340
Profeta's law, syphilitic infections and, i, 66; xvii, 74
Progeria, incidence of, xiii, 162
Prognosis, acute rheumatic fever, xiv, 396
— cerebrospinal meningitis, xiv, 285
— chickenpox, xiv, 77
— diphtheria, xiv, 168
— epidemic encephalitis, xiv, 262
— German measles, xiv, 67
— glandular fever, xiv, 318
— influenza, xiv, 383
— malaria, xiv, 218
— measles, xiv, 49
— mumps, xiv, 150
— poliomyelitis, xiv, 244
— rabies, xiv, 327
— scarlet fever, xiv, 23
— septic sore-throat, xiv, 311
— smallpox, xiv, 95
— surgical, growth and, xv, 2
— tetanus, xiv, 302
— tuberculous meningitis, xiv, 348
— typhoid fever, xiv, 201
— whooping-cough, xiv, 129
Progressive chronic arthritic disease, course of, vii, 104
— diagnosis of, vii, 104
— etiology of, vii, 99
— nomenclature of, vii, 98
— pathology of, vii, 102
— prognosis of, vii, 105, 107
— signs and symptoms of, vii, 103
— treatment of, vii, 106
Progressive muscular atrophy, Aran-Duchenne's, v, 69
— Charcot-Marie-Tooth's, v, 69
— clinical course of, vi, 246
— diagnosis of, vi, 247
— differential diagnosis, v, 69
— etiology of, vi, 246
— general considerations of, iii, 250
— hand type, vii, 251
— infantile (Werdnig-Hoffman type), vii, 252
— muscular dystrophy differentiated from, vi, 247
— neural of Charcot-Marie-Tooth, v, 215
— pathology of, vi, 246
— rarity of, v, 61
— symptoms of, vi, 246
— treatment of, vi, 247
— Werdnig-Hoffmann's, v, 69
Progressive neural muscular atrophy (Charcot-Marie-Tooth), vii, 252
Progressive pigmentary dermatosis, angioma serpiginosum differentiated from, xvi, 298
— diagnosis of, xvi, 299
— etiology of, xvi, 299
— incidence of, xvi, 298
— symptoms of, xvi, 299
— treatment of, xvi, 299
Progressive polyarticular arthritis, vi, 106
Progressive scleroderma, xvi, 302
Prolapse, bladder, incidence of, xix, 205
— postpartum care of, prevention of, i, 160
— rectal, etiology of, xv, 345
— — newborn, iii, 196
— — treatment of, xv, 346
Proliferative periostitis, hereditary syphilis and, xvii, 246
Pronephron, embryology of, xix, 1
Prophylactic immunization, prevention of "colds" by, iv, 132
Prophylaxis, newborn, ii, 121
— — Credé, ii, 125
— — hemorrhagic diseases of newborn and, ii, 238
Proportions, body, age and, iv, 30

Proprietary food, malnutrition and, iv, 152
Prostate, newborn, anatomy of, iii, 259
Prostration, pregnancy and, cystoma and, i, 42
Protection, mother and child, prenatal care and, i, 149-175
Protein, amino-acids in, x, 11
— amount required, iv, 53; xii, 66
— animal, milk impairing gastric digestion of, xii, 130, 134
— — salt and vitamins in, xii, 131
— average ratio of, iv, 40
— Bence-Jones, significance of, xx, 8
— blood, ii, 75
— caloric value of various foods and, x, 192, 193; xiii, 16
— cerebrospinal, percentage of, v, 16
— convulsions and, v, 137
— digestion of, xii, 49
— encephalitis and, v, 99
— foods containing, x, 27
— foreign, asthma and sensitization to, ix, 110
— — pollen fevers and sensitization to, ix, 117
— — serum disease from, xiv, 292
— — treatment of heart disease by injections of, xviii, 216
— formula changes involving, normal infant and, xii, 88
— functions of, x, 38; xiii, 5
— growth and, iv, 14
— human milk, xii, 162, 182
— importance of, xii, 66
— infant's requirements of, x, 12
— intestinal digestion of, viii, 141
— lactalbumin in human milk, x, 12
— milk containing, x, 27
— needs in older children, x, 13
— newborn digestion of, ii, 89
— nursing mother's diet and, xii, 182
— presence in meconium, ii, 92
— principal function of, x, 11
— results of deficiency of, x, 13
— results of faulty metabolism of, xii, 52
— serum and plasma, significance of, xx, 130
— tuberculous meningitis and, v, 97
Protein allergy, viii, 319
Protein indigestion, character of stools in, xx, 72
Protein metabolism, ii, 142
Protein milk, composition of, xii, 35
Protein sensitization, foreign, asthma and, ix, 113
— — chronic rhinitis and, ix, 11
— susceptibility and, viii, 317
Protein therapy, puerperal sepsis and, i, 103
Prothrombin, clotting and, ii, 232
— hemorrhagic disease from deficiency of, iii, 119
Prothrombin time of blood, xx, 37
Protoiodid, mercury, administration of, iii, 56
Prune juice, bottle feeding supplemented by, xii, 131
Prunes, constipation during pregnancy and, i, 166
Prurigo, dermatitis herpetiformis differentiated from, xvi, 105
— diagnosis of, xvi, 82
— etiology of, xvi, 82
— popular urticaria differentiaetd from, xvi, 79, 80, 82
— pathology of, xvi, 82
— prognosis of, xvi, 83
— scabies differentiated from, xvi, 166
— symptoms of, xvi, 81
— treatment of, xvi, 82
Prurigo ferox, xvi, 81
Prurigo mitis, xvi, 81
Prurigo nodularis, xvi, 81
Prurigo simplex acutus, xvi, 78
Prurigo vulgaris, xvi, 81
Pruritus, lichenification and, xvi, 141
Pseudochromidrosis, xvi, 276
Pseudodiphtheria, Epstein's, iii, 188
Pseudohermaphroditism, determination of sex in, xix, 223
Pseudohermaphroiditism femininus, iii, 268
Pseudohermaphroditism masculinus, iii, 269
Pseudohypertrophic dystrophy, disability in, v, 63
— heredity and, v, 63
— Landouzy-Déjerine type of, v, 64
— treatment, v, 65

Pseudoparalysis, Parrot's, vii, 141, 149
— — congenital syphilis and, iii, 44
— — differential diagnosis of, iii, 52
— syphilitic, scurvy differentiated from, x, 226
— syphilitic epiphysitis causing xvii, 243
— — treatment of, xvii, 281
Psoas abscess, acute infectious arthritis and, vi, 60
— acute infectious spondylitis and, vi, 62
— hip-joint tuberculosis differentiated from, vi, 82
— treatment of, vi, 66
Psoas contracture, diagnosis of, vi, 64
Psoriasis, diagnosis of, xvi, 128
— eczema differentiated from, xvi, 118, 137
— etiology of, xvi, 127
— general considerations of, iii, 331
— lichen planus differentiated from, xvi, 144
— lupus vulgaris differentiated from, xvi, 228
— nail changes due to, xvi, 268
— pathology of, xvi, 127
— pityriasis rosea differentiated from, xvi, 140
— prognosis of, xvi, 133
— symptoms of, xvi, 124
— treatment of, xvi, 129
— vitiligo differentiated from, xvi, 293
Psychiatry, mental disorders and, v, 158
— pediatrics and, v, 160
Psychic disturbances, tuberculosis in childhood causing, xiv, 355
Psychological conflicts, deviations due to, iv, 4
— preventive pediatrics and, iv, 69
Psychology, pubescent, iv, 67
Psychometric measurements, iv, 81
Psychoneuroses, familial syphilis causing, xvii, 106
Psychoses, parturition and, i, 6, 107
Psychotherapy, respiratory diseases and, ix, 255
Pterygoid ulcers, iii, 188
Ptosis, visceral, viii, 270
Ptyalin, carbohydrate digestion by, x, 33
— prematurity and, ii, 168
— salivary secretion and, ii, 84
Ptyalism, causes of, viii, 53
Puberty, metabolism and, xiii, 12
— precocious, etiology of, xix, 223
Pubescence, age and weight variations during, iv, 16
— annual growth during, iv, 26, 27
— average annual weight gain during, iv, 27
— cardiac disease during, iv, 121, 126, 127
— education during, iv, 91, 94
— goitre increase and, iv, 121, 125
— growth cycle during, iv, 26
— height, weight, age table for, iv, 22, 23
— importance of, iv, 67
— posture and, iv, 32
— psychology of, iv, 67
— rheumatic disease during, iv, 121
— sex education during, iv, 98
— sex influencing growth during, iv, 26
— visual defects during, iv, 121
Pubic lice, xvi, 157
Public Health, exhibits and, i, 157
— midwife and, i, 154
— nurses and, maternity work of, i, 159, 174, 175
— prenatal care and, i, 2, 149-175
Public Health regulations, cerebrospinal meningitis, xiv, 293
— chickenpox, xiv, 78
— diphtheria, xiv, 185
— epidemic encephalitis, xiv, 264
— German measles, xiv, 67
— influenza, xiv, 386
— malaria, xiv, 221
— measles, xiv, 59
— mumps, xiv, 151
— poliomyelitis, xiv, 252
— rabies, xiv, 329
— scarlet fever, xiv, 32
— septic sore-throat, xiv, 312
— smallpox, xiv, 102
— tetanus, xiv, 307
— tuberculosis, xiv, 372
— typhoid fever, xiv, 207

Public Health regulations, vaccination and, xiv, 114
— whooping-cough, xiv, 139
Puerile breathing, ix, 92
Puerperal hemorrhage, maternal deaths due to, i, 4
Puerperal infections, abortion and, i, 6, 43, 47
— bacteriology of, i, 87
— blood transfusion, dosage, i, 103, 104
— Census reports of, i, 2
— charts, illus., i, 100, 102
— chemical treatment of, i, 104
— eclampsia and, i, 92
— endometritis and, i, 93
— erysipelas in newborn from, iii, 18
— frequency of, i, 90
— general considerations of, i, 86-105
— gonococcus causing, i, 61, 94
— hygienic prevention of, i, 95, 96
— labor followed by, i, 150
— leukocyte count in, i, 101
— maternal deaths due to, i, 4, 5, 11, 86
— metritis and, i, 93
— midwives' responsibility in, i, 153
— miscarriage and, i, 47
— mortality rates in, i, 90
— operative treatment of, i, 91, 104
— pathology of, i, 88
— placental, i, 91, 94
— predisposing causes of, i, 91-95
— prenatal care and, i, 5, 12
— protein therapy and, i, 103
— serums in, i, 99-103
— specific treatment of, i, 99
— Staphylococcus aureus causing, i, 87
— streptococcus causing, i, 87
— symptomatology of, i, 93
— thrombophlebitis and, i, 94
— thrombosis and, i, 89
— treatment of, i, 95-104
Puerperal insanity, i, 40
Puerperal sepsis, i, 86-105
— artificial feeding and, ii, 157
— breast feeding prevented by, ii, 151
Puerperal ulcer, i, 88
Puffiness, ankle and foot, pregnancy and, i, 162
Puffiness, eye, pregnancy and, i, 168
— toxemias and, i, 37
Pulex irritans, iii, 348
Pulex penetrans, xvi, 168, 170
Pulled elbow, clinical features of, xv, 93
Pulmonary abscess, general considerations of, iii, 86
— pulmonary tuberculosis differentiated from, xiv, 351
— sputum in, characteristic appearance of, xx, 84
Pulmonary artery, anomalies of, iii, 112
Pulmonary atelectasis, iii, 87
Pulmonary embolism, maternal death from, i, 11, 33
Pulmonary gangrene, sputum in, characteristic appearance of, xx, 84
Pulmonary hypertrophic osteo-arthropathy, vii, 80
Pulmonary tuberculosis, anemia secondary to, xi, 70
— blood-count in, xi, 47
— bronchopneumonia and, ix, 130, 131
— chronic, diagnosis of, ix, 242
— — pathology of, ix, 241
— — prognosis of, ix, 243
— — symptoms of, ix, 242
— chronic pneumonia and, ix, 168
— clinical characteristics of, xiv, 350
— cough as a symptom of, ix, 228
— differential diagnosis of, xiv, 351
— foreign bodies in respiratory tract and, ix, 191
Pulmonary valve, pathological physiology of, xviii, 47
Pulmonic stenosis, anatomical considerations of, xviii, 133, 134
— clinical considerations of, xviii, 139
— electrocardiographic determination of, xviii, 184
Pulmonic thrombi, multiple, arsphenamin injections causing, xvii, 271
Pulse, abruptio placentæ and, i, 55
— bounding, convulsions at labor and, i, 38
— Corrigan, pregnancy and, i, 31
— study of, xviii, 103
Pulse rate, newborn, ii, 55

Pulse rate, newborn, average during first 8 days, ii, 56
— rheumatic fever affecting, xviii, 55
Puncture, cistern, technic of, xx, 96
— exploratory, abscess of lung and, ix, 174
— lumbar, anatomical factors in, vii, 8
— — method of therapeutic use of, ix, 279
— — technic of, xx, 97
— sinus, technic of, xx, 128
— vein, technic of, xx, 128
— ventricular, technic of, xx, 96
Pupil, flaccid paralysis and, v, 27
Pupillary reflex, newborn, ii, 113
Purgatives, therapeutic use of respiratory diseases and, ix, 263
Purpura, abdominal, diagnosis of, viii, 274
— — symptoms of, viii, 273
— — treatment of, viii, 274
— cachectic, blood changes in, xx, 53
— characteristics of, xi, 189
— classification of, xvi, 67
— diagnosis of, xvi, 70
— differentiation between thrombopenic and non-thrombopenic types of, xi, 208
— essential, viii, 273
— etiology of, xvi, 70
— forms of, xi, 189
— hemorrhagic, blood changes in, xx, 63
— Henoch's blood changes in, xx, 53
— — diagnosis of, viii, 274
— — first description of, xi, 5
— — hematuria and, xix, 69
— — intussusception differentiated from, viii, 260
— — symptoms of, viii, 273
— — treatment of, viii, 274
— idiopathic, blood changes in, xx, 53
— idiopathic non-thrombopenic, case history of, xi, 205
— — course of, xi, 209
— — diagnosis of, xi, 208
— — etiology of, xi, 205
— — physical signs of, xi, 207
— — treatment of, xi, 209
— idiopathic visceral, xi, 5
Purpura, infectious, viii, 273
— non-thrombopenic, idiopathic, xi, 205
— original description of, xi, 1, 3
— pathology of, xvi, 70
— rheumatic, blood changes in, xx, 53
— rheumatic infection causing, xviii, 72
— scurvy differentiated from, vii, 212
— secondary non-thrombopenic, case history of, xi, 210
— — diagnosis of, xi, 211
— — etiology of, xi, 209
— — treatment of, xi, 212
— secondary (symptomatic) thrombopenic, case history of, xi, 201
— — diagnosis of, xi, 203
— — treatment of, xi, 204
— surgical aspects of, xv, 51
— symptomatic, blood changes in, xx, 53
— symptomatology of, xvi, 66, 69
— thrombopenic, blood changes in, xx, 63
— — idiopathic purpura hæmorrhagica, xi, 190
— — secondary (symptomatic), xi, 190
— treatment of, xvi, 70
— types of, xi, 190
Purpura annularis telangiectodes, xvi, 295
Purpura fulminans, blood changes in, xx, 54
— early description of, xi, 5
— symptoms of, xvi, 69
Purpura hæmorrhagica, blood changes in, xx, 63
— blood-platelets in, xi, 5, 22
— epistaxis and, ix, 18
— hemophilia differentiated from, viii, 274
— idiopathic, blood-picture of, xi, 197
— — case history of, xi, 190
— — course of, xi, 198
— — diagnosis of, xi, 198
— — etiology of, xi, 194
— — physical signs of, xi, 197
— — symptoms of, xi, 196
— — treatment of, xi, 199

Purpura hæmorrhagica, scurvy differentiated from, x, 226
— surgical aspects of, xv, 51
— symptoms of, viii, 273; xvi, 69
— treatment of, viii, 274
Purpura rheumatica, symptoms of, xvi, 68
Purpura simplex, symptoms of, xvi, 68
Purulent meningitis, v, 95
— cerebrospinal fluid in, xx, 104
— cerebrospinal leukocytosis in, v, 15
Purulent nephritis, acute, xx, 13. *See also* Pyuria.
Purulent pleuritis, pericarditis following, iii, 119
Purulent rhinitis, ix, 6
Purulent sialadenitis, acute, iii, 197
Pus, localized foci of, blood-count of, xi, 47
Pus cells, puerperal infections and, i, 87
— pyelitis cases and, i, 35, 36
— urine of pregnancy and, i, 21
Pustules, isolation of newborn with, ii, 137
Putamen, symptoms of lesions of, v, 71
P wave, significance of, ii, 59
Pyelitis, accessory nasal sinus disease and, ix, 34
— acute bronchitis and, ix, 104
— acute malaria differentiated from, xiv, 218
— ascending infection causing, xix, 144
— bacteriology of, xix, 140
— cerebrospinal meningitis complicated by, xiv, 282, 292
— chronic form of, absent local symptoms in, xix, 149
— — cord bladder and, xix, 156
— — dilated ureter without stricture and, xix, 153
— — obstruction in posterior urethra and, xix, 158
— — ureteral duplication and, xix, 153
— complications of, xix, 161
— course of, xix, 161
— definition of, xix, 138
Pyelitis, diagnosis of, xix, 163
— — special diagnostic aids in, xix, 167
— — technic of catheterization in, xix, 166
— — urinalysis in, xix, 164
— etiology of, xix, 139
— general considerations of, iii, 270
— hematogenous infection causing, xix, 143
— history of, xix, 138
— incidence of, xix, 139
— localization of infection in, xix, 139
— malnutrition and, x, 188
— mode of infection in, xix, 143
— pathology of, xix, 141
— perinephritis and perinephritic abscess and, xix, 174
— pregnancy and, i, 25, 34-36
— prognosis of, xix, 169
— relapses in, xix, 161
— scurvy and, xiii, 126
— surgical importance of, xv, 359
— symptoms of, xix, 146
— treatment of, xv, 361; xix, 169, 173
— typhoid, viii, 191, 192
— typhoid fever differentiated from, xiv, 200
Pyelocystitis, rupture of solitary renal cyst causing, xix, 15
Pyelonephritis, acute, pathology of, xix, 141
— glomerulonephritis and, xix, 117
— pregnancy and, i, 35
Pyemia, chickenpox followed by, xiv, 74
— epistaxis and, ix, 18
— labor followed by, i, 93, 94
— newborn, iii, 12
Pyknolepsy, v, 139
Pyloric stenosis, congenital hypertrophic, clinical features of, xv, 285
— — diagnosis of, xv, 288
— — incidence of, xv, 283
— — operative results of, xv, 296
— — operative treatment of, xv, 292
— — treatment of, xv, 290
— hypertrophic, diagnosis and differentiation of, viii, 119

Pyloric stenosis, hypertrophic, etiology of, viii, 114
— — incidence of, viii, 114
— — nomenclature and history of, viii, 113
— — pathology and physiology of, viii, 115
— — prognosis of, viii, 117, 124
— — symptoms of, viii, 113, 115
— — treatment of, viii, 121
— — — surgical, viii, 123
— malnutrition and, iv, 152
Pylorospasm, viii, 113
— clinical picture of, viii, 126
— congenital pyloric stenosis causing, iii, 143
— diagnosis and differentiation of, viii, 128
— etiology of, viii, 126
— prognosis of, viii, 129
— symptoms of, viii, 127
— treatment of, viii, 127
— vomiting caused by, iii, 174
Pylorus, congenital stenosis of, iii, 139
— — symptoms of stasis and retention caused by, xii, 115, 189
— — treatment of, iii, 143
— spasm of, alkalosis caused by, xx, 174
Pyogenic cocci, skin diseases due to, general considerations of, xvi, 203
Pyogenic cord infections, fetal death and, i, 48
Pyogenic infections, urinary tract, ascending infection causing, xix, 144
— — bacteriology of, xix, 140
— — chronic form of, xix, 149
— — complications of, xix, 161
— — course of, xix, 161
— — definition of, xix, 138
— — diagnosis of, xix, 163
— — etiology of, xix, 139
— — hematogenous infection causing, xix, 143
— — history of, xix, 138
— — incidence of, xix, 139
— — localization of infection in, xix, 139
Pyogenic infections, urinary tract, mode of infection in, xix, 143
— — pathology of, xix, 141
— — perinephritis and perinephritic abscess and, xix, 174
— — prognosis of, xix, 169
— — relapses in, xix, 161
— — symptoms of, xix, 146
— — treatment of, xix, 169, 173
Pyogenic osteomyelitis, tuberculosis of bones and joints differentiated from, vii, 117
Pyorrhea umbilici, iii, 403
Pyothorax, ix, 199
Pyramidal tracts, adduction of legs and, v, 8
— knee jerk and, v, 11
Pyuria, acute follicular tonsillitis causing, ix, 54
— chronic tonsillitis and, ix, 59
— classification of, xx, 14
— definition of, xx, 13
— diagnosis of, xx, 14

Q-R-S interval, meaning of, xviii, 166
Q-R-T interval, ii, 63
Quality and quantity of breast milk, diet affecting, xii, 159, 166, 181
Quarantine, pertussis showing futility of, iv, 140
— relative futility of, iv, 129
Quartan malaria, etiology of, xiv, 210
Quartz lamp, asthma and, ix, 116
— enlarged non-tuberculous bronchial glands and, ix, 211
— pathogenic microörganisms and, and, vii, 218
— respiratory diseases and, ix, 260
— results of exposure to, vii, 229
— rickets treated by, vii, 200; xiii, 117
— spasmophilia and, x, 253
— tetany and, v, 135; x, 253
— types of, vii, 228
Quinin, abortion and, i, 47
— acute rhinitis and, ix, 7
— dermatitis caused by, xvi, 48, 53
— induction of labor with, i, 110
— malaria diagnosis and, xiv, 218
— malaria treatment and, xiv, 220

Quinin, pollen fevers and, ix, 119
— urticaria caused by, xvi, 74
Quinsy, ix, 64
— acute follicular tonsillitis causing, ix, 54
— symptoms and treatment of, viii, 42
— treatment of, xv, 180
Quotient, energy, milk production and, xii, 160
— respiratory, diabetes mellitus and, xiii, 101
Q wave, significance of, ii, 59

Rabies, characteristics of, xv, 11
— clinical course of, xiv, 326
— clinical features of, xv, 12
— definition of, xiv, 324
— diagnosis of the biting animal, xiv, 327
— etiology of, xiv, 325
— history of, xiv, 324
— incidence of, xiv, 324
— Pasteur treatment of, xiv, 328
— pathology of, xiv, 326; xv, 13
— prevention of, xiv, 328
— prognosis of, xiv, 327
— Public Health regulations for, xiv, 329
— symptoms of, xiv, 326
— synonyms of, xiv, 324
— treatment of, xiv, 328; xv, 13
Race, amount of hemoglobin influenced by, xx, 27
— comparative size of head at birth, ii, 20
— dental hypoplasias from syphilis in relation to, xvii, 215
— early characteristics of, ii, 13
— food and stature of, x, 2, 9
— height-age curve and, x, 87
— incidence of neurosyphilis in relation to, xvii, 175
— milk secretion and, ii, 143
— rheumatic heart disease and, xviii, 6
— syphilis and, i, 77
— weight of newborn and, x, 45
— weight variations due to, ii, 16
Rachischisis, vii, 47
Rachitic hypoplasia, syphilitic dental stigmata and, xvii, 221
Rachitic rosary, fetal chondrodystrophy and, vii, 16
Radiodermatitis, etiology of, xvi, 41
— pathology of, xvi, 41
— prognosis of, xvi, 41
— symptoms of, xvi, 39
— telangiectasia in, xvi, 295
— treatment of, xvi, 41
Radio-ulnar synostosis, iii, 287
Radium, adenoids treated with, ix, 74
— alopecia caused by, xvi, 257
— dermatitis caused by, xvi, 33, 39
— exophthalmic goiter and, xiii, 50
— joint neoplasms and, vi, 126
— mediastinal tumors and, ix, 214
— nevi and, xvi, 11; xv, 61
— spinal cord tumors and, v, 127
— thymic enlargement and, xiii, 90
— tonsils treated with, ix, 63
Radius, absence of, vi, 278; vii, 56
— postpartum fractures of, treatment of, xv, 92
Rage, la, synonyms of, xiv, 324
— preventive pediatrics and, iv, 69
Râles, bronchopneumonia type of, ix, 129
— lobar pneumonia and, ix, 147
— significance of, ix, 97
Ramisection, sympathetic, v, 145
Ranula, definition of, viii, 54
— general considerations of, iii, 193, 197
— treatment of, xv, 176
Rash, inherited syphilis causing, xvii, 113
— Swift's disease and, x, 277
Rat-bite fever, spirillum of, neurosyphilis treated by inoculation with, xvii, 267
Ravaglione, synonyms of, xiv, 69
Raynaud's disease, diagnosis of, xvi, 300
— etiology of, xvi, 300
— late inherited syphilis and, xvii, 170
— prognosis of, xvi, 300
— scleroderma differentiated from, xvi, 304
— symptoms of, xvi, 299
— treatment of, xvi, 300

Reaction, newborn, blood, ii, 74
— — urine, ii, 101
Recent dislocations, vi, 177
Recklinghausen's disease, diagnosis of, xvi, 26
— etiology of, xvi, 26
— pathology of, xvi, 26
— prognosis of, xvi, 27
— symptoms of, xvi, 25
— treatment of, xvi, 27
Recolac, composition of, xii, 34
Record forms for infancy, iv, 191, 192
Rectal anesthesia, labor of cardiac cases and, i, 33
Rectal examinations, gonorrhea and, i, 62
— pregnancy and, i, 160
— sepsis caused by, i, 96
Rectal polyp, ileus caused by, iii, 196
Rectal temperature, newborn, ii, 49
Recti abdominalis muscles, diastasis of, ventral hernia and, xv, 265
Rectovaginal fistula, iii, 167
Rectovesical fistula, embryology of, xix, 8
Rectum, atresia of, iii, 166
— congenital abnormalities of, viii, 287
— congenital atresia of, iii, 135
— dehydration and introduction of liquids by way of, xiii, 42
— development of, xv, 341
— embryology of, viii, 287
— fissure of, viii, 293
— injuries to, iii, 187
— ischiorectal abscess, xv, 347
— malformations of, xv, 342
— polypus of, viii, 294
— — incidence of, xv, 344
— — treatment of, xv, 345
— prolapse of, iii, 196; viii, 289
— — etiology of, xv, 345
— — treatment of, xv, 346
— spina bifida and paralysis of, vii. 49
— sterile at birth, ii, 118
— surgery of, malformations, xv, 341
Recurrent bone tumors, vi, 196
Recurrent bronchitis, accessory nasal sinus disease and, ix, 34
Recurrent laryngeal nerves, delayed speech due to lesions of, v, 196
Recurrent pyuria, classification of, xx, 14
— urinary findings in, xx, 15
Recurrent sore-throat, rheumatic infection causing, xviii, 67
Recurrent vomiting, viii, 134
Red blood-cells, abnormal forms of, xi, 15
— age and possible variation in number of, xi, 38
— average number of, xi, 39
— comparison of counts in sinus and peripheral blood, xx, 34
— counting of, xi, 24
— destruction and formation of, xi, 14
— equilibrium between blood formation and destruction, xi, 13
— formation and destruction of, xi, 14
— formation from fetal life to childhood, xi, 12
— fragility of, xx, 30
— — determination of, xi, 29
— functions of, xi, 6
— infancy and childhood and, xv, 50
— newborn, characteristics of, ii, 67
— normal morphology and staining of, xi, 11
— number during adolescence, xi, 44
— number during childhood, xi, 43
— number during infancy, xi, 41
— number of, xx, 28
— original description of, xi, 1
— reproduction of, xi, 13
— toxemias of pregnancy and, i, 37
Red nucleus, v, 2, 46
Reduplicated second heart-sound, pathological physiology of, xviii, 43
Reflexes, cerebrospinal meningitis and, xiv, 275
— deep, v, 10
— later infancy and childhood and, xii, 140, 149
— newborn, ii, 113
— peroneal, tetany and, xiii, 35
— poliomyelitis and, xiv, 241
— superficial, 11

Refraction, errors of, convulsions and, v, 137
Refractive index, ii, 65
Regeneration of nerve cells, v, 25, 35, 129
Regularity, infant and child feeding, xii, 137
Regurgitation, simple, infancy and, viii, 92
— *See also* insufficiency, xviii
Relative polycythemia, xi, 215
Remittent fever, synonyms of, xiv, 209
Renal calculi, diagnosis of, xix, 182
— formation of, xix, 180
— symptoms of, xix, 181
— treatment of, xv, 363; xix, 182
Renal conditions, pregnancy and, i, 6, 18
— — care of, i, 32, 166
— — death in utero and, i, 107
— — eclampsia and, i, 39
— — history and, patient's, i, 17
— — puerperal sepsis and, i, 91
— — pyelitis in, i, 34, 35
— — urine analysis and, i, 18, 21, 160, 162, 165
Renal cysts, xv, 364
Renal diabetes, blood-sugar in, xx, 164
Renal disease, bilateral hematogenous, amyloidosis and, xix, 101
— — chronic diffuse nephropathy and, xix, 125
— — edema as a symptom of, xix, 75
— — hemorrhagic nephritis and, xix, 101
— — infantile nephropathy, xix, 129
— — nephrosis and, xix, 78
— — renal stasis, xix, 128
Renal dwarfism, xx, 153
Renal epistaxis, xix, 70
Renal failure costs, xix, 35
Renal glycosuria, diabetes mellitus differentiated from, xiii, 103
Renal hemorrhage, iii, 269
Renal infantilism, xx, 153
Renal rickets, clinical symptoms of, xx, 153
— laboratory findings in, xx, 154
Renal stasis, symptoms of, xix, 128
Renal syphilis, xix, 192
Renal threshold, significance of, xiii, 14
Renal tuberculosis, diagnosis of, xix, 190
— incidence of, xix, 188
— pathology of, xv, 365
— symptoms of, xix, 190
— treatment of, xv, 366; xix, 191
Renal tumors, clinical features of, xv, 367
— diagnosis of, xv, 368
— incidence of, xv, 366
— treatment of, xv, 369
Rennin, newborn, ii, 87
— — meconium showing presence of, ii, 92
Repeated vomiting, iii, 173
Reportable diseases, practicing physician and, xiv, 8
Reproduction, inanition affecting, x, 204
Repulsion, preventive pediatrics and, iv, 70
Resection, rib, empyema and, xv, 232
Resistance, bodily, xiv, 4
Resorcin, dermatitis caused by, xvi, 42
Respiration, artificial, axphyxia neonatorum and, ii, 198
— Cheyne-Stokes, cyanosis and, ii, 206
— initiation of, nerve elements in, v, 21
— intracranial injuries affecting, v, 43
— newborn, i, 136, 137
— — anatomy of organs of, ii, 52
— — peculiarities in, ii, 172
— — physiology of, ii, 52
— — plus ratio of, ii, 52
— — rate of, ii, 52
Respiratory alkalosis, abnormal excretion of carbon dioxid causing, xiii, 37
Respiratory excursion, age and variations of, ix, 88
Respiratory infections, upper, malnutrition and, iv, 153
— — prevention of, iv, 131
Respiratory quotient, ii, 96
— diabetes mellitus and, xiii, 101

Respiratory system, asphyxia neonatorum and, ii, 189
— convulsions and, v, 138
— diseases of, acidosis in, dietotherapy of, ix, 256
— — actinotherapy in, ix, 260
— — counterirritants in, ix, 256
— — diet in, ix, 256
— — drugs used in, ix, 261
— — general hygiene in, ix, 255
— — general therapeutics in, ix, 254
— — heliotherapy in, ix, 260
— — hydrotherapy in, ix, 259
— — pharmaceutics in, ix, 261
— — psychotherapy in, ix, 255
— — therapeutic methods in, ix, 267
— foreign bodies in, ix, 187
— lumbar puncture affecting nerve control of, v, 119
— mongolism and infection of, v, 191
— prematurity signs in, ii, 165
— tuberculosis of, xiv, 350
Rest, art of infant feeding and, xii, 146
— heart disease and, xviii, 214
— hygiene and, iv, 83
— posture depending on, iv, 37
— pregnancy and, i, 21, 24, 32, 46, 47, 142, 161, 162, 167
— sleep and, importance of, iv, 83
Retention, water, inanition and, x, 214
— — obesity and, x, 153
Reticulocytes, significance of, xi, 15
Retina, choked discs in encephalitis, v, 99
— congenital pigmentation of, iii, 356
— significance of ophthalmoscopic examination of, v, 18
Retinitis, eclampsia and, i, 39
Retrodisplacements, uterine, i, 19, 161
Retroperitoneal abscess, xv, 311
Retroperitoneal sarcoma, Wilms' tumor differentiated from, xix, 186
Retroperitoneal tuberculosis, xv, 302
Retropharyngeal abscess, acute, clinical features of, xv, 78
— diagnosis of, viii, 44; ix, 43
— etiology of, ix, 42
Retropharyngeal abscess, symptoms of, viii, 43; ix, 42
— treatment of, viii, 45; ix, 44; xv, 179
Retropharyngeal lymphadenitis, viii, 43
Retroplacental blood, Wassermann reaction of, i, 76
Retrotonsillar abscess, ix, 64
— acute follicular tonsillitis causing, ix, 54
Retroversion, prevention of, i, 160
Revaccination, smallpox, advisability of, iv, 140
— time for, xiv, 112
Reverdin's skin grafts, scar contractures and, vi, 205
Reynaud's disease, newborn, iii, 118
Rhagades, latent syphilis and, xvii, 229
— nursing rendered difficult by, viii, 98
— syphilitic infants and, i, 75
Rheumatic aortitis, pathology of, xviii, 37
Rheumatic carditis, subacute bacterial endocarditis differentiated from, xviii, 186
Rheumatic fever, acute, arthritis of hereditary syphilis differentiated from, xvii, 247
— — blood-count in, xi, 47, 49
— — complications of, vii, 95; xiv, 393
— — definition of, xiv, 388
— — diagnosis of, vii, 95; xiv, 395
— — epidemiology of, xiv, 388
— — etiology of, vii, 90; xiv, 388
— — leukocyte counts in, xx, 44
— — pathology of, vii, 92; xiv, 389
— — prognosis of, vii, 98; xiv, 396
— — prophylaxis of, xiv, 396
— — scurvy differentiated from, vii, 211
— — Still's disease differentiated from, vii, 104
— — symptoms of, vii, 92; xiv, 390
— — synonyms of, xiv, 388
— — treatment of, vii, 97; xiv, 396
— blood changes in, xviii, 54
— chorea and, xviii, 18
— communicability of, xviii, 75

Rheumatic fever, convalescent care of, xviii, 58, 217
— pathogenesis of, xviii, 16
— pathology of, blood-vessels and, xviii, 37
— — brain and, xviii, 18
— — heart and, xviii, 21
— — joints and, xviii, 18
— — kidneys and, xviii, 40
— — lungs and, xviii, 39
— — pleura and, xviii, 39
— — subcutaneous nodules and, xviii, 19
— — summary of, xviii, 40
— pericarditis and, xviii, 124
— pleural effusion and, xviii, 128
— pleurisy following, ix, 193
— pregnancy and, i, 31
— recurrence of, tendency to, xviii, 211
— salicylates in treatment of, xviii, 216
— scarlet fever and, xviii, 192
— scope of the term, xviii, 51
— treatment of, xviii, 55, 216
Rheumatic heart disease, bacteriology of, xviii, 15
— communicability of, xviii, 4
— effort syndrome in, xviii, 85
— etiology of, age and, xviii, 9
— — bacteriology and, xviii, 15
— — climate in, xviii, 6
— — environment and, xviii, 12
— — heredity and, xviii, 11
— — race in, xviii, 6
— — seasonal flux of, xviii, 8
— — sex and, xviii, 11
— family incidence of, xviii, 11
— groups of, xviii, 4
— history taking in, xviii, 74
— incidence of, xviii, 11
— pathological physiology of, xviii, 42, 44
— pathology of, blood-vessels, xviii, 37
— — endocardium, xviii, 24
— — myocardium, xviii, 21
— — pericardium, xviii, 35
— — summary of, xviii, 40
— pericardial effusion in, xviii, 125
— pericarditis in, xviii, 124
Rheumatic heart disease, symptoms of, xviii, 79
— *See also* Carditis.
Rheumatic infection, diseases included as, xviii, 52
— recurrent attacks of, prognosis of heart disease and, xviii, 210
Rheumatic nodules, subcutaneous, rheumatic fever and, xviii, 69
Rheumatic pericarditis, pathology of, xviii, 35
Rheumatic pneumonia, xviii, 39
Rheumatic polyarthritis, acute, convalescent care of, xviii, 58
— — symptoms and signs of, xviii, 52
— — treatment of, xviii, 55
Rheumatic purpura, xi, 189
— blood changes in, xx, 53
Rheumatism, acute articular, acute osteomyelitis differentiated from, vii, 70
— — complications of, vii, 95
— — diagnosis of, vii, 95
— — etiology of, vii, 90
— — pathology of, vii, 92
— — prognosis of, vii, 98
— — scurvy differentiated from, xiii, 125
— — symptoms of, vii, 92
— — synonyms of, xiv, 388
— — treatment of, vii, 97
Rheumatism, acute inflammatory, acute osteomyelitis differentiated from, xv, 135
— acute inflammatory, chronic tonsillitis and, ix, 60
— erythema nodosum following, xvi, 64
— erythema scarlatiniforme and, xvi, 59
— inflammatory, complications of, vii, 95
— — etiology of, vii, 90
— — diagnosis of, vii, 95
— — pathology of, vii, 92
— — prognosis of, vii, 98
— — symptoms of, vii, 92
— — treatment of, vii, 97
— pubescence showing increase in, iv, 121
— scurvy differentiated from, x, 226

Rheumatism, *See also* Rheumatic fever.
Rheumatoid arthritis, course of, vii, 104
— diagnosis of, vii, 104
— etiology of, vii, 99
— nomenclature of, vii, 98
— pathology of, vii, 102
— prognosis of, vii, 105, 107
— signs and symptoms of, vii, 103
— treatment of, vii, 106
Rhinitis, acute, complications of, ix, 6
— — diagnosis of, ix, 6
— — etiology of, ix, 2
— — hereditary susceptibility to, ix, 4
— — pathology of, ix, 4
— — predisposing causes of, ix, 3
— — prognosis of, ix, 6
— — prophylaxis of, ix, 8
— — symptoms of, ix, 5
— — treatment of, ix, 6
— atrophic, diagnosis of, ix, 14
— — symptoms of, ix, 14
— — synonyms for, ix, 13
— — treatment of, ix, 14
— chronic, adenoids causing, ix, 70
— — classification of forms of, ix, 9
— chronic atrophic, late inherited syphilis and, xvii, 171
— — simple, etiology of, ix, 9
— — — symptoms of, ix, 10
— — — treatment of, ix, 10
— diagnosis of hereditary syphilis and, xvii, 243
— diphtheritic, pathology of, ix, 16
— — symptoms of, ix, 16
— — treatment of, ix, 17
— hypertrophic, etiology of, ix, 12
— — symptoms of, ix, 12
— — treatment of, ix, 13
— inherited syphilis causing, xvii, 113, 124
— newborn, treatment of, iii, 78
— pollakiuria precipitated by, xix, 67
— purulent, ix, 6
— syphilitic, diagnosis of, ix, 15
— — incidence of, xvii, 124
— — nursing hindered by, viii, 98
— — "snuffles" and, iii, 42
— — symptoms of, ix, 15
Rhinitis, syphilitic, treatment of, ix, 15
— traumatic, treatment of, ix, 17
— tuberculous, treatment of, ix, 16
— vasomotor, ix, 117
Rhubarb, laxative use of, respiratory diseases and, ix, 263
Rhus antigen, xvi, 46
Rhus dermatitis, symptoms of, xvi, 44
— treatment of, xvi, 45
Rhus diversiloba, dermatitis caused by, xvi, 46
Rhus toxicodendron, xvi, 46
Rhus venenata, dermatitis caused by, xvi, 46
Rhythm, atrioventricular, electrocardiographic determination of, xviii, 173
— nodal, electrocardiographic determination of, xviii, 173
Ribs, cervical, surgery of, xv, 188
— newborn, deformities of, iii, 282
— resection of, empyema and, xv, 232
— tuberculosis of, treatment of, xv, 225
Rice, beriberi and, x, 266
— bottle feeding supplemented by, xii, 134
Rickets, acute bronchitis and, ix, 102
— advanced type of, vii, 188
— age and, vii, 174
— anemia secondary to, xi, 64
— artificial feeding and, ii, 159
— blood changes in, xx, 175
— blood chemistry in, vii, 189
— bone deformities in, x, 236, 238
— bone, general characteristics of, vii, 176
— bone pathology in, vi, 182
— breast feeding and, i, 140
— celiac, calcium loss causing, xx, 177
— celiac disease differentiated from, viii, 214
— chemical pathology of, vii, 185
— complications of, vii, 193
— congenital, iii, 306
— course of, x, 243
— curve of weakness in, x, 242
— definition of, iv, 122
— delayed, vii, 190
— delayed dentition and, x, 107

Rickets, diagnosis of, vii, 191; x, 242; xiii, 115
— diet and, vii, 171
— ductless glands and, vii, 175
— dwarfism and, x, 137, 138; xiii, 152
— endocrine influence on, vii, 175
— etiology of, vii, 168; x, 231; xiii, 114
— extra-osseous pathology of, vii, 184
— fetal, iii, 306; vi, 192; vii, 11, 174
— — bodily changes in, vii, 19
— — body growth and, vii, 14
— — etiology of, vii, 14
— — pathology of, vii, 14
— — treatment of, vii, 19
— — X-ray studies of, vii, 18
— florid, vii, 176, 186
— food and, vii, 171
— funnel-chest caused by, vii, 50
— Harrison's groove in, x, 237
— heliotherapy in, vii, 227
— history of, vii, 167; x, 229
— hypodermic medication in, x, 247
— incidence of, x, 230; xiii, 112
— incipient, vii, 176
— internal secretions and, vii, 175
— late, vii, 190; x, 241
— latent, vi, 187
— maternal influences on, vii, 174
— medicinal treatment of, ii, 186
— metabolism of salts and, xiii, 17
— microscopic anatomy of, vii, 184
— morbid anatomy of, xiii, 113
— ossification centers a criterion of, ii, 165
— pathology of, vii, 176; x, 234
— — chemical, vii, 185
— — extra-osseous, vii, 184
— postural defects caused by, iv, 35
— premature infants and, ii, 172; xii, 105
— prevention of, iv, 122
— prognosis of, x, 243; xiii, 116
— progressive muscular atrophy and, v, 69
— prophylaxis of, vii, 196; xiii, 117
— racial susceptibility to, vii, 169
— renal, clinical symptoms of, xx, 153
— — laboratory findings in, xx, 154
— rosary of, vii, 186
Rickets, scurvy differentiated from, vii, 192, 193
— signs and symptoms of, vii, 185; xiii, 115
— Still's disease and, vii, 107
— summary of general characteristics of, vii, 190
— surgical aspects of, xv, 41
— symptoms of, x, 236; xv, 43
— syphilis of bones associated with, vii, 140
— syphilitic osteochondritis and, i, 72
— teeth and, viii, 64
— tetany and, v, 130
— treatment of, vii, 196; x, 233, 244; xiii, 119
— tuberculosis of spine differentiated from, vi, 91; vii, 123
— ultraviolet rays and, x, 25
Riga's disease, viii, 12
Right-sided heart, electrocardiographic determination of, xviii, 184
Rigidity, age and craniovertebral, v, 5
— cerebrospinal meningitis causing, v, 78
— definition of, v, 2
— globus pallidus lesions causing, v, 71
— infantile paralysis showing, v, 104
— meningeal inflammation causing, v, 78
Ringed hair, xvi, 263
Ringworm, iii, 349
— alopecia due to, xvi, 256
— "black dot," alopecia areata differentiated from, xvi, 260
— blastomycosis differentiated from, xvi, 199
— diagnosis of, xvi, 182
— diffuse, pityriasis capitis differentiated from, xvi, 135
— eczema seborrheicum differentiated from, xvi, 137
— erythema multiforme differentiated from, xvi, 62
— favus differentiated from, xvi, 192
— glabrous skin, xvi, 177
— — diagnosis of, xvi, 182
— — psoriasis differentiated from, xvi, 128
— — treatment of, xvi, 188

Ringworm, gray patch, xvi, 174
— hand and foot, xvi, 178
— nail, xvi, 179
— — diagnosis of, xvi, 183
— — treatment of, xvi, 188
— pathology of, xvi, 180
— pityriasis rosea differentiated from, xvi, 140
— prognosis of, xvi, 188
— scalp, diagnosis of, xvi, 182
— — incidence of, xvi, 173
— — symptoms of, xvi, 174
— — treatment of, xvi, 183
— treatment of, xvi, 183
Risipola, synonyms of, xiv, 399
Risus sardonicus, tetamus and, iii, 32; xv, 9
Ritter's disease, iii, 323
— diagnosis of, xvi, 308
— etiology of, xvi, 308
— prognosis of, xvi, 309
— symptoms of, xvi, 307
— treatment of, xvi, 308
Roentgenograms, genito-urinary, preparation of patient, for, xix, 44
Roentgenotherapy, chronic pneumonia and, ix, 171
Roentgen rays, alopecia caused by, xvi, 257
— dermatitis caused by, xvi, 33, 39
— eczema and, xvi, 122
— effect on kidney of, xix, 26
— favus and, xvi, 193
— lichen planus and, xvi, 144
— psoriasis and, xvi, 132
— ringworm of scalp and, xvi, 184
— surgical examination and, xv, 6
— *See also* X-ray.
Rolando, fissure of, voluntary motion in relation to, v, 3
Rollier's heliotheraphy, vii, 223
— joint tuberculosis and, vi, 72
— tuberculosis and, xiv, 365
Rosacea, granulosis rubra nasi differentiated from, xvi, 278
Rosary, rachitic, vii, 186; x, 234; xiii, 113; xv, 43
— — fetal chondrodystrophy and, vii, 16
— scurvy causing, x, 221
Rosenstein, syphilis described by, xvii, 8
Roseola, smallpox differentiated from, xiv, 95
Roseola epidermica, blood-count in, xi, 47
Roseola infantum, synonyms of, xiv, 320
Rose spots, typhoid fever and, viii, 188
Ross-Jones' globulin test, xx, 98
Rotation volvulus, xv, 280
Rotch's sign, pericardial effusion and, xviii, 126
Rötheln, blood-count in, xi, 47
— synonyms of, xiv, 62
Rothlauf, synonyms of, xiv, 399
Roth's modified metabolism apparatus, xiii, 2, 5
Round bodies, Darier's, xvi, 310
Round shoulders, orthopedic management of, vi, 269
Round-worms, benign jaundice from, viii, 328
— intestinal infestation with, viii, 299
Routine chemical urinalysis, xx, 4
Roux, work on syphilis by, xvii, 15
Rubber bag technic, abruptio placentæ and, 56
— cardiac cases and, i, 33
— cervix dilatation and, i, 32
— induction of labor and, i, 38, 108, 109
— placenta prævia and, i, 59
Rubella, prevention undeveloped for, iv, 138
— scarlet fever differentiated from, xiv, 18
— synonyms of, xiv, 62
Rubeola, synonyms of, xiv, 34, 62
Rumination, course of, viii, 132
— description of, viii, 130
— diagnosis of, viii, 132
— etiology of, viii, 130
— mechanism of, viii, 130
— symptoms of, viii, 131
— treatment of, viii, 132; xii, 115
Rumpbell-Leede phenomenon, xvi, 70
Runabout period, anatomy during, x, 51
— length of, x, 50
Rupture, kidney, xix, 193

Rupture, membrane, infection following, i, 96
— muscle, vi, 210
— uterus, shock and, i, 133
— vein, birth and, i, 112
Rural communities, maternity protection in, i, 158, 159
— midwives in, i, 152
— mortality rate from sepsis in, i, 90
R wave, significance of, iii, 60
Saber-shin, latent syphilis causing, xvii, 227
— osteitis in childhood and, i, 73
— typical appearance of, vii, 147
Saccharomyces albicans, thrush caused by, iii, 190
Sacral teratoma, iii, 309
Sacral tumors, congenital, iii, 309
Sacrococcygeal fistulæ, congenital, surgery of, xv, 217
Sacrococcygeal sinuses, congenital, surgery of, xv, 217
Sacrococcygeal tumors, surgery of, xv, 215
Sacro-iliac disease, rarity in childhood, vii, 123
Sacro-iliac joint, orthopedic examination of, vi, 20
— plaster-of-Paris and, vi, 37
— traumatic injuries of, vi, 120
Sacrum, tumors of, surgery of, xv, 215
Saddle-nose, incidence of, xvii, 124
— latent syphilis causing, xvii, 227
Sahli hemoglobinometer, use of, xi, 25
Salicylates, acute infectious arthritis and, vi, 55
— chronic infectious arthritis and, vi, 105
— dermatitis caused by, xvi, 48
— rheumatic fever and, xviii, 55
— treatment of heart disease with, xviii, 216
Saline infusion, placental hemorrhage and, i, 56, 60
— shock prevention and, i, 131
Saline injections, sepsis neonatorum and, iii, 16
Saline solution, acidosis and administration of, x, 274
Saline solution, hypertonic, hydrocephalus and, v, 106
— — infantile paralysis and, v, 106
— peritonsillar abscess and, ix, 66
Saliva, cerebral palsy and drooling of, v, 149
— lenticular degeneration and, v, 74
— newborn, elements in, ii, 84
Salivary calculi, iii, 197
Salivary cysts, iii, 197
Salivary glands, abnormal development of, viii, 53
— absence of, viii, 54
— anatomical and functional considerations of, viii, 52
— cyst of, viii, 54
— diseases of, iii, 196
— — epidemic parotitis, viii, 56
— — parotitis (non-epidemic), viii, 56
— — sublingual inflammation, viii, 58
— — submaxillary inflammation, viii, 58
— disturbances of secretion of, viii, 53
— lymphatic enlargement affecting, viii, 59
— malformations of, iii, 197
— Mikulicz' disease of, viii, 55
— newborn, iii, 124
— stones obstructing ducts of, viii, 58
— suppuration of, surgery of, xv, 188
— syphilis affecting, viii, 59
— tumors of, iii, 199
Salivation, causes of, viii, 53
Salol, dermatitis caused by, xvi, 42
Salpingitis, uterine misplacement and, i, 21
Salt elimination, toxemias of pregnancy and, i, 37
Salt fever, xiii, 40
Salts, acidosis and alkalosis and, xiii, 17
— bile, fat digestion by, x, 30
— digestion of, xii, 53
— human milk, xii, 163
— metabolism of, ii, 95
— mineral, digestion of, x, 38
— — foods containing, x, 28
— — food value of, x, 17
— — metabolic importance of, x, 18
— — metabolism of, x, 38

Salts, mineral, milk and, x, 27
— — sunshine and, x, 25
— premature infant requirements of, xii, 105
— source of, xiii, 16
Salt solution, accessory nasal sinus disease and, ix, 36
— acute pharyngitis and, ix, 41
— chronic rhinitis and, ix, 11
— throat irrigation with, method of, ix, 285
Salvarsan, syphilis during pregnancy and, i, 81
— Vincent's angina and, ix, 47
Sanchez, syphilis studied by, xvii, 8
Sand flea, xvi, 170
Sandalwood oil, pyelitis of pregnancy and, i, 36
Sandbag, abdominal, primary shock and, i, 133
Santonin, accidental poisoning with, viii, 314
— Ascaris lumbricoides and, ix, 187
— dermatitis caused by, xvi, 48
Santorini, cartilages of, ix, 75
Sapremia, puerperal, bacteria causing, i, 88
— — decidua and, i, 89
— — lochia and, i, 88
— — postpartum uterus and, i, 92
— — symptomatology of, i, 93
Sarcoma, blastomycosis differentiated from, xvi, 199
— chloroma differentiated from, xi, 172
— diagnosis of, xvi, 334
— etiology of, xvi, 334
— granuloma pyogenicum differentiated from, xvi, 220
— hepatic, iii, 200
— incidence of, xvi, 331
— intestinal, xv, 339
Sarcoma osteogenic, vii, 162
— — types of, vi, 197
— periosteal, diagnosis of, vi, 198
— — frequency of, vi, 197
— — pathology of, vi, 198
— — prognosis of, vi, 199
— — symptoms of, vi, 198
— — treatment of, vi, 199
— — X-ray demonstration of, vi, 198
Sarcoma osteogenic, retroperitoneal, Wilms' tumor differentiated from, xix, 186
— salivary gland, viii, 17, 55
— suprarenal, iii, 389
— — anemia secondary to, xi, 79
— treatment of, xvi, 335
— umbilical, iii, 409
Sarcoptes scabiei, xvi, 166
Saturation index of blood, xx, 32, 33
Sayre adhesive dressing, application of, vi, 166
— clavicular fracture and, vi, 165
Sayre head traction, scoliosis and, vi, 267
Sayre suspension apparatus, vi, 39
Scabies, iii, 347
— diagnosis of, xvi, 166
— eczema differentiated from, xvi, 118
— etiology of, xvi, 165
— papular urticaria differentiated from, xvi, 80
— pathology of, xvi, 166
— prognosis of, xvi, 168
— symptoms of, xvi, 162
— treatment of, xvi, 166, 350
Scalds, clinical features of, xv, 15
— prognosis of, xv, 16
— treatment of, xv, 17
Scalene sign, lobar pneumonia and, ix, 148
Scales, types of, ii, 132
Scaley skin, xvi, 13
Scalp, avulsion of, xv, 154
— birth injuries of, xv, 152
— cellulitis of, xv, 154
— cysts of, xv, 156
— edema of, birth, i, 112
— erysipelas of, xv, 155
— furuncles of, xv, 154
— hematoma of, xv, 153
— pediculosis of, treatment of, xvi, 350
— ringworm of, diagnosis of, xvi, 182
— — incidence of, xvi, 173
— — symptoms of, xvi, 174
— — treatment of, xvi, 183
— tumors of, xv, 156
Scanning speech, Friedreich's ataxia and, vi, 250

Scaphoid, epiphysitis of, vi, 144
— Köhler's disease of, vi, 145
— — joint tuberculosis differentiated from, vi, 77
— osteitis of, vi, 145
Scaphoid bone, osteochondritis of, vii, 77
Scapula, congenital elevation of, iii, 283; vii, 49
— motion of, vi, 25
— postpartum fractures of, xv, 84
Scapulohumeral muscular atrophy, vii, 256
Scar, xvi, 317
— perioral, latent syphilis and, xvii, 229
Scar contractures, etiology of, vi, 201
— factors determining extent of, vi, 201
— peripheral nerve injury and, vi, 251
— prevention of, vi, 202
— treatment of, vi, 204
— Volkmann's, vi, 212
Scarlet fever, acute follicular tonsillitis differentiated from, ix, 53
— acute infectious arthritis and, vi, 50
— adenoids and, ix, 68
— bacteriology of, xiv, 11
— bronchopneumonia secondary to, ix, 122, 130
— complications of, xiv, 20
— — treatment of, xiv, 29
— definition of, xiv, 10
— diagnosis of, xiv, 18
— Dick test and, iv, 136
— differential diagnosis of, xiv, 18
— diphtheria bacilli in, xiv, 167
— diphtheria differentiated from, xiv, 168
— epidemiology of, xiv, 12
— epistaxis and, ix, 18
— erythema infectiosum differentiated from, xiv, 323
— etiology of, iv, 135; xiv, 10
— fetal death and, i, 48
— German measles differentiated from, xiv, 66
— growth affected by, xiii, 22
— heart complications in, xviii, 192
— hemolytic streptococci causing, iv, 136
Scarlet fever, history of, xiv, 10
— infant mortality and, iv, 111
— infection of fetus with, iii, 10
— influenza differentiated from, xiv, 383
— leukocytosis in, xx, 45
— measles differentiated from, xiv, 48
— milk as carrier of, xii, 14; xx, 122
— newborn and, iii, 26
— pathology of, xiv, 12
— pregnancy and, i, 17
— prematurity caused by, ii, 163
— prevention of, iv, 134; xiv, 25
— prognosis of, xiv, 23
— Public Health regulations for, xiv, 32
— puerperal infections originating from, i, 86
— rheumatic infections and, xviii, 78
— septic sore-throat differentiated from, xiv, 311
— skin blanching test in, xiv, 19
— smallpox differentiated from, xiv, 94
— specific treatment of, xiv, 30
— symptoms of, xiv, 13
— synonyms of, xiv, 10
— treatment of, xiv, 25, 27, 29
— tuberculin test negatived by, ix, 231
— types of, xiv, 16
— vaginitis associated with, xix, 229
Scarlatinal tonsillitis, viii, 41
Schafpocken, synonyms of, xiv, 69
Schamberg's disease, angioma serpiginosum differentiated from, xvi, 298
— diagnosis of, xvi, 299
— etiology of, xvi, 299
— incidence of, xvi, 298
— symptoms of, xvi, 299
— treatment of, xvi, 299
Schedules, breast feeding, xii, 180
— feeding, regularity of, xii, 137
Schick test, diphtheria and, iv, 133
— diphtheria susceptibility determination by, technic of, xiv, 179
— — value of, xiv, 160
Schistosoma japonicum, newborn and, iii, 35
Schlaftsucht, synonyms of, xiv, 254

Schlatter-Osgood's disease, vii, 75; xv, 141
— etiology of, vii, 77
— symptoms of, vii, 78
— treatment of, vii, 79
Schneiderian membrane, hemorrhage from, ix, 17
— hyperplasia of, ix, 12
— structure of, ix, 1
Schönlein's disease, blood changes in, xx, 53
School age, average normal gain during, iv, 26
— cardiac disease in, iv, 126
— clothing for, iv, 87
— diet during, iv, 62
— education and school life for, iv, 91
— examination record for, iv, 197
— exercise and play during, iv, 85
— goitre and, iv, 125
— health education in, iv, 100
— height, weight, age tables for, iv, 22, 23
— height, weight development during, iv, 28
— intake of food in calories during, iv, 40
— malnutrition in, iv, 154
— morbidity in, iv, 121
— mortality during, iv, 105
— posture in, iv, 32
— sex education in, iv, 97
— school hygiene during, iv, 180
— weight-height-age averages during, iv, 21
School hygiene, preventive pediatrics and, iv, 180
School life, iv, 91
Schools, nursery, v, 181
Schutzblättern, synonyms of, xiv, 104
Sciatic scoliosis, vi, 122
Science of nutrition, x, 7
Scissors gait, spastic cerebral paralysis causing, vi, 238
Sclerema edematosum, iii, 344
Sclerema adiposum, iii, 342
Sclerema neonatorum, iii, 342
— diagnosis of, xvi, 306
— etiology of, xvi, 306
— pathology of, xvi, 306
Sclerema neonatorum, prognosis of, xvi, 307
— sclerederma differentiated from, xvi, 305
— symptoms of, xvi, 305
— treatment of, xvi, 306
Scleroderma, diagnosis of, xvi, 304
— etiology of, xvi, 304
— hereditary syphilis and, i, 67
— pathology of, xvi, 304
— prognosis of, xvi, 305
— Raynaud's disease differentiated from, xvi, 300
— symptoms of, xvi, 302
— treatment of, xvi, 305
— types of, xvi, 302
Scleroderma neonatorum, iii, 340
Sclerosing osteomyelitis, Garré's, diagnosis of, vi, 141
— — local manifestations of, vi, 139
— — pathology of, vi, 139
— — prognosis of, vi, 141
— — symptoms of, vi, 139
— — treatment of, vi, 141
Sclerosis, amyotrophic lateral, vii, 251
— congenital, iii, 281; vii, 51, 52
— definition of, vi, 22, 260
— deformity in, vi, 263
— diagnosis of, vi, 267
— etiology of, vi, 262
— examination of, vi, 265
— factors predisposing to, vi, 262
— lateral, Little's disease differentiated from, vi, 240
— multiple, abdominal reflex and, v, 12
— — delayed speech and, v, 196
— — general pathology of, v, 220
— orthopedic management of, vi, 260
— prognosis of, vi, 267
— rickets causing, vi, 182
— sciatic, vi, 122
— sex influencing incidence of, vi, 262
— spinal anomalies and, vi, 278
— symptoms of, vi, 265
— torticollis and, vi, 293
— treatment of, vi, 267
— tuberculosis of spine and, vii, 123
— x-ray examination of, vi, 265
Scopolamin, labor anesthesia and, i, 29, 33

Scopolamin-morphin narcosis, use during labor, ii, 123
Scorbutus, vi, 188; vii, 203
Scraped beef, bottle feeding supplemented by, xii, 133
Scratching, dermatitis caused by, xvi, 33
Scrofuloderma, etiology of, xvi, 234
— pathology of, xvi, 234
— symptoms of, xvi, 233
— treatment of, xvi, 235
Scrotal tongue, xvi, 341
Scrotum, gangrene of, erysipelas causing, iii, 19
Scurvy, acute, vii, 208; x, 224
— — treatment of, vii, 215
— acute bronchitis and, ix, 102
— acute epiphysitis differentiated from, vii, 150
— acute osteomyelitis differentiated from, xv, 135
— acute rheumatic fever differentiated from, vii, 96
— antiscorbutic substance, vii, 207
— blood changes in, vii, 205
— blood signs in, xiii, 121
— breast feeding and, i, 140
— clinical forms of, vii, 208
— diagnosis of, vii, 211; x, 226; xiii, 122; xv, 39
— differential diagnosis of, xiii, 124
— epistaxis and, ix, 18
— etiology of, vii, 205; x, 219; xiii, 119
— florid, x, 224
— gingival, viii, 14
— hematuria and, xix, 69
— hemorrhage in, vii, 204
— history of, x, 218
— incidence of, xiii, 120
— infantile, vii, 203
— — etiology of, xvi, 71
— — symptoms of, xvi, 71
— — treatment of, xvi, 71
— latent, x, 222
— metabolism in, xiii, 121
— orthopedic phases of, vi, 188
— pathogenesis of, vii, 205
— pathology of, x, 221, 224
— — general, vii, 203
— — microscopic, vii, 204
Scurvy, poliomyelitis differentiated from, xiv, 244
— prevention of, iv, 124
— prognosis of, vii, 213; x, 226; xiii, 126
— prophylaxis of, xiii, 126
— rickets differentiated from, vii, 192
— signs and symptoms of, xiii, 120
— Still's disease differentiated from, vii, 105
— subacute, x, 223
— surgical aspects of, xv, 34
— symptoms of, vii, 208; x, 222
— time of incidence of, x, 221
— treatment of, vii, 214; x, 227; xiii, 127
— tuberculosis of bones and joints differentiated from, vii, 116
— vitamin C preventing, x, 23
— x-ray signs of, vii, 210
Seasons, diarrhea and, xii, 124
— formula change and, xii, 77
— growth and, xiii, 18
— infant mortality and, iv, 112
— premature infant mortality and, xii, 105
— rheumatic heart disease and, xviii, 8
Seat-worm, intestinal infestation with, viii, 296
Sebaceous cyst, xvi, 282
Sebaceous glands, diseases of, acne vulgaris, xvi, 280
— — atheroma, xvi, 282
— — comedo, xvi, 279
— — cysts, xvi, 282
— — milium, xvi, 282
— vernix caseosa derived from, ii, 109
Seborrheic eczema, psoriasis differentiated from, xvi, 128
— treatment of, xvi, 349
Second generation, transmission of syphilis by inheritance to, xvii, 63
Secondary anemia, blood changes in, xx, 49
— blood-count in, xi, 61
— blood loss causing, xi, 59
— blood parasites causing, xi, 77
— chemical poisons causing, xi, 80

Secondary anemia, destruction or defective formation of blood causing, xi, 63
— empyema and, ix, 204
— infectious diseases causing, xi, 69
— — course of, xi, 76
— — physical signs of, xi, 75
— — symptoms of, xi, 75
— — treatment of, xi, 77
— nutritional diseases causing, xi, 63
— — course of, xi, 68
— — prognosis of, xi, 68
— — symptoms of, xi, 66
— — treatment of, xi, 68
— poisons causing, xi, 80
— scurvy causing, vii, 209
— tumors causing, xi, 79
Secondary non-thrombopenic purpura, case history of, xi, 210
— diagnosis of, xi, 211
— etiology of, xi, 209
— treatment of, xi, 212
Secondary purpura, symptoms of, xvi, 69
Secondary syphilitic lesions, late, skin and mucous membranes showing, xvii, 126
Secondary thrombopenic purpura, case history of, xi, 201
— diagnosis of, xi, 203
— treatment of, xi, 204
Secretions, internal, nervous disorders and, v, 171
— milk, physiology of, xii, 155
— newborn, ii, 110
Secretin, ii, 89
— protein digestion and, x, 37
Secundines, removal of, infections and, i, 92
Sedatives, therapeutic use of, respiratory diseases and, ix, 264
Sedimentation time, xx, 38
Seeds, vitamin content of, x, 284
Segregation, feeble-mindedness and, iv, 10
Selective eaters, xii, 139
Self-abasement, preventive pediatrics and, iv, 70
Self-assertion, preventive pediatrics and, iv, 70
Self-consciousness, development period of, x, 75
Self-control, labor and, i, 169
Self-display, preventive pediatrics and, iv, 70
Sella turcica, dystrophy from abnormalities of, v, 65
— erosion of, convulsions and, v, 137
— tumor causing distortion of, v, 118
Seminal vesicle, embryology of, xix, 5
Senna leaves, constipation during pregnancy and, i, 166
Sensation, dissociation of, v, 216
Sense, organs of, newborn, ii, 114
Sensitization, foreign protein, pollen fevers and, ix, 117
Sensitization tests, asthma and, ix, 113
— pregnancy and, i, 101, 103
Separation, epiphyseal, vi, 166
Sepsis, acute, anemia due to, xx, 50
— — leukocytosis in, xx, 48
— chronic, blood-picture of, xi, 76
— — icterus index in, xx, 40
— congenital cyanosis and, ii, 204
— erythema scarlatiniforme and, xvi, 59
— generalized, blood-count in, xi, 47
— hemorrhagic disease and, ii, 228
— mortality due to, ii, 3
— overwhelming, blood-count in, xi, 51
— prematurity and, ii, 171
Sepsis, puerperal, i, 86-105
— — abortion and, i, 6, 43, 47
— — bacteriology of, i, 87
— — blood transfusion, dosage, i, 103, 104
— — Census reports of, i, 2
— — charts, illus., i, 100, 102, 114
— — chemical treatment of, i, 104
— — eclampsia and, i, 92
— — endometritis and, i, 93
— — frequency of, i, 90
— — gonococcus causing, i, 61, 94
— — hygienic prevention of, i, 95, 96
— — labor followed by, i, 150
— — leukocyte count in, i, 101
— — maternal deaths due to, i, 4, 5, 11, 86
— — metritis and, i, 93

Sepsis, puerperal, midwives' responsibility in, i, 153
— — miscarriage and, i, 47
— — mortality rates in, i, 90
— — operative treatment of, i, 91, 104
— — pathology of, i, 88
— — placental, i, 91, 94
— — predisposing causes of, i, 91-95
— — prenatal care and, i, 5, 12
— — protein therapy and, i, 103
— — serums in, i, 99-103
— — specific treatment of, i, 99
— — Staphylococcus aureus causing, i, 87
— — streptococcus causing, i, 87
— — symtomatology of, i, 93
— — thrombophlebitis and, i, 94
— — thrombosis and, i, 89
— — treatment of, i, 95-104
Sepsis neonatorum, atria of, iii, 12
— Buhl's disease and, iii, 4
— cause of, iii, 12
— congenital cyanosis and, ii, 205
— course of, iii, 15
— diagnosis of, iii, 15
— frequency of, iii, 13
— "habitus septicus" in, iii, 15
— hemorrhage and, iii, 185
— lymph nodes seldom enlarged in, iii, 7
— meaning of, iii, 12
— organisms causing, iii, 13
— pathology of, iii, 13
— prognosis of, iii, 15
— symptoms of, iii, 14
— temperature and weight in, iii, 14
— treatment, iii, 16
— type of organisms causing, iii, 13
— Winckel's disease and, iii, 2
Septal abnormalities of newborn heart, iii, 106
Septic endocarditis, typhoid fever differentiated from, xiv, 200
Septic scarlet fever, xiv, 17
Septic sore-throat, bacteriology of, xiv, 308
— complications of, xiv, 311
— definition of, xiv, 308
— diagnosis of, xiv, 311
— epidemiology of, xiv, 310
— history of, xiv, 308
Septic sore throat, incidence of, xiv, 310
— milk transmission of, xii, 13
— prognosis of, xiv, 311
— prophylaxis of, xiv, 311
— Public Health regulations for, xiv, 312
— signs and symptoms of, xiv, 310
— synonyms of, xiv, 308
— treatment of, xiv, 311
— ulcerative stomatitis and, viii, 27
Septicemia, epistaxis and, ix, 18
— heart complications in, xviii, 193
— nephrosis and, xix, 80
— newborn, iii, 12
— pneumococcic, lobar pneumonia causing, ix, 160
— puerperal, labor and, i, 86, 88
— — causes of, i, 90, 91
— scarlet fever differentiated from, xiv, 19
— tubercle bacillus, ix, 228
— typhoid fever differentiated from, xiv, 200
Sequestrum, acute osteomyelitis and, xv, 133
— definition of, vi, 129; vii, 67
Serampion, synonyms of, xiv, 34
Serological tests, interpretation of, xvii, 46
Serology of tuberculosis, xiv, 369
Serum, antimeningococcic, cerebrospinal meningitis therapy and, xiv, 288
— antistreptococcus, scarlet fever and, xiv, 30
— antitetanic, use of, xv, 11
— blood, refractive index of, ii, 65
— convalescent, infantile paralysis and, v, 105
— — measles prophylaxis and, xiv, 54
— — mumps immunity and, xiv, 151
— — poliomyelitis and, xiv, 248
— dysentery, viii, 182
— erysipelas, xiv, 401
— horse, streptococcic infection and, i, 101
— intracranial pressure at birth and injections of, i, 116
— meningococcic, v, 90
— pneumonococcic, i, 99

Serum, polyvalent antistreptococcic, i, 99, 101, 103
— prevention of sepsis and, i, 99-103
— puerperal sepsis and, i, 87
— — dosage, i, 101
Serum and plasma proteins, significance of, xx, 130
Serum arthritis, vii, 88
Serum disease, symptoms and treatment of, xiv, 292
Serum rashes, xvi, 54
Serum sickness, puerperal sepsis and, i, 101
Serum therapy, lobar pneumonia and, ix, 167
— method of use of, respiratory diseases and, ix, 282
Severe diffuse glomerulitis, clinical features of, xx, 136
Sever's operation, obstetrical paralysis and, vi, 246
Sewing machine, use of, pregnancy and, i, 24
Sex, blood-pressure and, ii, 58
— body proportions influenced by, ii, 31
— development of consciousness of, x, 75
— enuresis and, xix, 50
— growth and, ii, 42; xiii, 18
— heredity and, iv, 8
— incidence of neurosyphilis in relation to, xvii, 178
— incidence of syphilis in relation to, xvii, 86
— metabolism and, xiii, 12
— precocious development of, symptoms of, xiii, 99
— predetermination of, inanition and, x, 205
— rheumatic heart disease and, xviii, 11
— total heat output and, xiii, 7
— weight loss little affected by, ii, 37
— weight variations due to, ii, 17
Sex education, hygiene and, iv, 97
— pubescent, iv, 98
— school age, iv, 97
Sex instinct, development of, iv, 67
— hygiene and, iv, 86
Sexual functions, inanition and, x, 204
Sexual relations, pregnancy and, i, 20, 45, 95, 161
— syphilitic's regulation of, i, 67, 81
Shelters, confinement, public, i, 157
Sheppard-Towner Act, governmental interest in sociology shown by, ii, 2
Shingles, xvi, 87
Shirt, infant, ii, 129
Shock, abortion and, i, 43
— abruptio placentæ and, i, 55
— accidents of labor and, i, 130-135
— acidotic, i, 130-133
— anaphylactic, adrenalin for control of, ix, 266
— blood-pressure in, i, 131
— burns and scalds and, xv, 15
— causes of, i, 130
— infections and, i, 91
— labor and, i, 150
— placenta prævia and, i, 57
— primary, i, 130
— secondary, i, 133
— skull fractures and, xv, 161
— surgical, clinical features of, xv, 23
— — treatment of, xv, 24
— therapeutic, arsphenamin and, xvii, 279
— thrombophlebitis and, i, 104
Shoes, lifts in, dystrophies and, v, 66
— pregnancy and, i, 162
— proper types of, vii, 276
Shoulder delivery, i, 121, 122, 123, 128
— fractures resulting from, i, 127
— subluxation due to, birth palsy due to, i, 124
— technic of, i, 128
Shoulder-girdle, deformities of, vii, 49
Shoulder joint, acute infectious arthritis and, vi, 66
— congenital dislocation of, vii, 49
— fixation of, vi, 43
— orthopedic examination of, vi, 25
— periarthritis of, vii, 264
— poliomyelitis and, vi, 225
— — operative measure for, vi, 233
— tuberculosis of, vii, 131

Shoulder joint, tuberculosis of, management of, vi, 95
Shoulders, comparison of adult and infant, vii, 9
Sial-adenitis, acute purulent, iii, 197
— — surgery of, xv, 188
Sickle-cell anemia, blood-picture of, xi, 96; xx, 49
— etiology of, xi, 95
— symptoms of, xi, 96
— treatment of, xi, 97
Sighing respiration, significance of, ix, 88
Sight, blurring, pregnancy and, i, 168
— early characteristics of, ii, 7, 114
— presence at birth, ii, 114
Silver nitrate, accessory nasal sinus disease and, ix, 36
— accidental poisoning with, viii, 314
— acute edema of uvula and, ix, 48
— acute follicular tonsillitis and, ix, 56
— atrophic rhinitis and, ix, 14
— Credé prophylactic with, iii, 366
— eyes of newborn and, i, 62, 137, 169
— gonorrhea treated with, i, 62
— nipple cracks treated with, i, 143
— prophylactic treatment of eyes with, ii, 124
Simple chronic rhinitis, etiology of, ix, 9
— symptoms of, ix, 10
— treatment of, ix, 10
Simple goiter, incidence of, xiii, 45
— prevention of, iv, 125
— prophylaxis of, xiii, 46
— treatment of, xiii, 47
Simple hereditary atrophic muscular dystrophy, vii, 255
Simple myositis, vii, 234
Simple purpura, xi, 189
Simple regurgitation, viii, 92
Sims' position, varicosities during pregnancy and, i, 168
Simulidæ, xvi, 160
Simulium venustrum, iii, 348; xvi, 160
Sino-auricular block, electrocardiographic determination of, xviii, 172
Sinus, accessory nasal, disease of, ix, 21
— — — chronic tonsillitis and, ix, 59
Sinus, accessory nasal, disease of, complications of, ix, 34
— — — diagnosis of, ix, 32
— — — etiology of, ix, 26
— — — incidence of, ix, 31
— — — pathology of, ix, 27
— — — predisposing factors in, ix, 27
— — — related affections, ix, 30
— — — symptoms of, ix, 27
— — — treatment of, ix, 35
— — — x-ray technic in, ix, 31
— — histology of, ix, 26
— — newborn, iii, 66
— — rheumatic infection and, xviii, 69
— congenital sacrococcygeal, surgery of, xv, 217
— ethmoid, examination of, ix, 24
— maxillary, examination of, ix, 22
— pilonidal, iii, 309
— sphenoid, examination of, ix, 25
— superior petrosal, v, 22
— urogenital, development of, xix, 8
Sinus arhythmia, diagnosis of, xviii, 199
— electrocardiographic determination of, xviii, 170
Sinus lactens, xii, 156
Sinus puncture, technic of, xx, 128
Sinusitis, anemia caused by, xx, 50
Siphon drainage, empyema and, xv, 233
Siren formation, anatomy of, vii, 58
Sisto's sign, colic in infancy and, viii, 100
— congenital syphilis and, viii, 129
Situs inversus, iii, 155
Size, fetus, i, 17, 19
— newborn decrease in, ii, 32
— — early changes in, ii, 32
— — factors influencing, ii, 13, 32
— parents', labor and, i, 19
Skeleton, special differences between adult and infant, vii, 6
Skimmed milk, composition of, xii, 25, 32
Skin, acrodynia and, x, 277
— active hyperemia of, xvi, 57
— affections of, orthopedic, vi, 49
— animal parasites affecting, iii, 347

Skin, artificial inflammations of, xvi, 33
— blueness of, neonatal, i, 137
— bullous diseases of, xvi, 84, 98
— care of, pregnancy and, i, 167
— cause of affections of, iii, 315
— cerebrospinal meningitis affecting, xiv, 274
— chilling of, neonatal, i, 138
— circulatory disturbances of, xvi, 56
— congenital abnormalities of, iii, 316; xvi, 1
— congenital syphilis and, iii, 42
— depigmentation of, xvi, 288
— diseases of, actinomycosis, xvi, 196
— — adenoma sebaceum, xvi, 22
— — albinismus, xvi, 288
— — angiokeratoma, xvi, 297
— — angioma serpiginosum, xvi, 297
— — angioneurotic edema, xvi, 76
— — animal parasites causing, xvi, 151, 162, 170
— — bacilli causing, xvi, 224
— — Bazin's disease, xvi, 235
— — bedbugs, xvi, 157
— — black flies, xvi, 160
— — blastomycosis, xvi, 198
— — brown-tailed moth causing, xvi, 161
— — callositas, xvi, 324
— — chicken lice, xvi, 159
— — chilblain, xvi, 37
— — chloasma, xvi, 288
— — cicatrix, xvi, 317
— — clavus, xvi, 324
— — creeping eruption, xvi, 169
— — demodex folliculorum, xvi, 168
— — depigmentation, xvi, 288
— — dermatitis exfoliativa neonatorum, xvi, 307
— — dermatitis factitia, xvi, 54
— — dermatitis gangrænosa infantum, xvi, 222
— — dermatitis herpetiformis, xvi, 102
— — dermatitis medicamentosa, xvi, 47
— — dermatitis vegetans, xvi, 220
— — dermatitis venenata, xvi, 41
— — diphtheria, xvi, 248
— — ecthyma, xvi, 210
Skin, diseases of, eczema, xvi, 108
— — eczema seborrheicum, xvi, 135
— — edema neonatorum, xvi, 307
— — epidermolysis bullosa, xvi, 18
— — epithelioma, xvi, 331
— — erysipelas, xvi, 214
— — erysipeloid, xvi, 215
— — erythema gluteale, xvi, 35
— — erythema hyperæmicum, xvi, 57
— — erythema induratum, xvi, 235
— — erythema infectiosum differentiated from, xiv, 323
— — erythema intertrigo, xvi, 34
— — erythema multiforme, xvi, 59
— — erythema nodosum, xvi, 63
— — erythema pernio, xvi, 37
— — erythema scarlatiniforme, xvi, 58
— — favus, xvi, 188
— — fleas, xvi, 158
— — follicular impetigo, xvi, 216
— — formulary of preparations for treatment of, xvi, 346
— — fungi causing, xvi, 173
— — furunculosis, xvi, 217
— — grain itch, xvi, 159
— — granuloma annulare, xvi, 240
— — granuloma pyogenicum, xvi, 220
— — harvest mite, xvi, 168
— — hereditary edema of the legs, xvi, 309
— — herpes simplex, xvi, 84
— — herpes zoster, xvi, 87
— — hydroa puerorum, xvi, 97
— — hydroa vacciniforme, xvi, 94
— — hyperpigmentation, xvi, 284
— — ichthyosis, xvi, 13
— — infantile scurvy, xvi, 71
— — keloid, xvi, 315
— — keratosis follicularis, xvi, 309
— — keratosis follicularis contagiosa, xvi, 310
— — keratosis palmaris et plantaris, xvi, 17
— — lentigo, xvi, 287
— — leprosy, xvi, 243
— — lichen nitidus, xvi, 239
— — lichen planus, xvi, 142
— — lichen scrofulosorum, xvi, 237
— — lichen spinulosus, xvi, 145
— — lichen urticatus, xvi, 78

Skin, diseases of, lipoma, xvi, 327
— — lupus erythematosus, xvi, 241
— — lupus erythematosus disseminatus, xvi, 243
— — lupus vulgaris, xvi, 224
— — malignant new growths of, xvi, 331
— — measles differentiated from, xiv, 48
— — melanoma, xvi, 334
— — midges, xvi, 160
— — Milroy's disease, xvi, 309
— — molluscum contagiosum, xvi, 325
— — morphea, xvi, 304
— — mosquito bites, xvi, 160
— — multiple abscesses of infants, xvi, 219
— — multiple benign cystic epithelioma, xvi, 27
— — multiple pigmented sarcoma, xvi, 334
— — napkin erythema, xvi, 35
— — neurofibromatosis, xvi, 25
— — nevus, xvi, 1
— — papular urticaria, xvi, 78
— — papulonecrotic tuberculid, xvi, 238
— — parapsoriasis, xvi, 133
— — pediculosis, xvi, 152
— — pemphigus, xvi, 98
— — pemphigus neonatorum, xvi, 210
— — pigmentary nevi, xvi, 5
— — pityriasis capitis, xvi, 134
— — pityriasis rosea, xvi, 137
— — pityriasis rubra pilaris, xvi, 145
— — pompholyx, xvi, 93
— — progressive pigmentary dermatosis, xvi, 298
— — prurigo, xvi, 81
— — psoriasis, xvi, 124
— — purpura, xvi, 66
— — pyogenic cocci causing, xvi, 203
— — radiodermatitis, xvi, 39
— — Raynaud's disease, xvi, 299
— — Recklinghausen's disease, xvi, 25
— — ringworm, xvi, 173
— — Ritter's disease, xvi, 307
— — sand flea, xvi, 170
— — sarcoma, xvi, 331
— — scabies, xvi, 162
— — scar, xvi, 317
Skin, diseases of, Schamberg's disease, xvi, 298
— — sclerema neonatorum, xvi, 305
— — scleroderma, xvi, 302
— — scrofuloderma, xvi, 233
— — scurvy, xvi, 71
— — sporotrichosis, xvi, 199
— — stinging insects, xvi, 161
— — sunburn, xvi, 38
— — syringocystoma, xvi, 28
— — telangiectasia, xvi, 295
— — ticks, xvi, 158
— — tinea cruris, xvi, 194
— — tuberculids, xvi, 236
— — tuberculosis, xvi, 223
— — tuberculosis ulcerosa, xvi, 232
— — tuberculosis verrucosa cutis, xvi, 231
— — urticaria, xvi, 73
— — urticaria pigmentosa, xvi, 28
— — vaccination complicated by, xiv, 114
— — vascular nevi, xvi, 1
— — verruca, xvi, 318
— — vitiligo, xvi, 289
— — warts, xvi, 318
— — worms causing, xvi, 170
— — xanthoma, xvi, 329
— — xeroderma pigmentosum, xvi, 19
— — zoster, xvi, 87
— dystrophies of, xvi, 302
— eruptions of, acute rheumatic fever and, xiv, 395
— erythema of Jacquet, iii, 319
— erythematous disturbances of, xvi, 56
— erythredema and, x, 277
— fever following destruction of, xiii, 39
— gumma of, hereditary syphilis and, xvii, 248
— herpes affecting, xvi, 84
— hyperpigmentation of, xvi, 284
— infectious granulomata of, xvi, 196, 198
— inflammations of, artificial, xvi, 33
— itching of, xvi, 81
— lichenification of, xvi, 141
— major ectodermal defect iii, 317
— measles and, xiv, 42
— newborn, care of, ii, 127

Skin, newborn, early characteristics of, ii, 10.
— — edematous infections of, prematurity and, ii, 172
— — sensations present at birth, ii, 115
— — vernix caseosa and, ii, 109
— new growths of, xvi, 315
— — malignant, xvi, 331
— passive hyperemia of, xvi, 56
— pedunculated flaps and, vi, 205
— pellagra and, x, 257
— pollen fevers affecting, ix, 118
— postarsphenamin reactions of, xvii, 273
— prurigo of, xvi, 81
— purpura of, xvi, 66
— scaling diseases of, xvi, 124
— scar contractures following loss of, vi, 201
— scarlet fever desquamation of, xiv, 16
— scurvy and, xvi, 66
— serum disease and, xiv, 292
— stigmata of, latent syphilis and, xvii, 229
— Swift's disease and, x, 277
— syphilis of, clinical incidence of, xvii, 116, 126
— — diagnosis of hereditary syphilis and, xvii, 243
— — neonatal, i, 75
— — pathological evidence of, xvii, 27
— tumors of, iii, 346
— urticaria and, xvi, 73, 78
— vascular diseases of, xvi, 295
— vesicular diseases of, xvi, 84
Skin-grafts, burns and scalds and, xv, 20
— scar prevention and, vi, 203
— scar treatment and, vi, 204
— types of, vi, 205
Skull, birth injuries to, iii, 290
— defects of, v, 50
— depression of, iii, 290
— development of, x, 52, 74, 77
— fetal, compressibility, v, 22
— fractures of, iii, 294
— — cerebral compression in, xv, 161
— — cerebral irritation from, xv, 161
Skull, fractures of, cerebral shock or concussion in, xv, 161
— — clinical features of, xv, 159
— — diagnosis of, xv, 162
— — epistaxis caused by, ix, 18
— — general considerations of, xv, 157
— — pathology of, xv, 158
— — prognosis of, xv, 163
— — treatment of, xv, 158, 163
— malformations of, iii, 279
— syphilitic changes in, vii, 142
— syphilitic osteoperiostitis of, xvii, 137
Skull-cap, defective development of, hydrocephalus, vii, 53
Skull injuries, forceps extraction and, i, 116
Sleep, art of infant feeding and, xii, 147
— enuresis and, xix, 49
— hygiene and, iv, 83
— infant's, i, 174
— metabolism during, xiii, 4
Sleeping sickness, general considerations of, v, 97, 98
— newborn and, iii, 31
— synonyms of, xiv, 254
Small intestine, atresia of, iii, 145
— development of, x, 66
—newborn, infection of, ii, 118
— stenosis of, iii, 145
Smallpox, blood-count in, xi, 47
— chickenpox differentiated from, xiv, 76, 94
— clinical varieties of, xiv, 90
— complications of, xiv, 93
— definition of, xiv, 80
— diagnosis of, xiv, 93
— differential diagnosis of, xiv, 94
— epistaxis and, ix, 18
— etiology of, xiv, 83
— fetal, i, 48; xiv, 92
— history of, xiv, 80
— infection of fetus with, iii, 10
— infective period of, xiv, 85
— leukocytosis in, xx, 44
— medical treatment of, xiv, 99
— methods of vaccination in, iv, 139
— newborn and, iii, 20
— pathology of, xiv, 82

Smallpox, pregnancy and, xiv, 92
— prematurity caused by, ii, 163
— prevention of, iv, 139; xiv, 96
— prognosis of, iii, 22; xiv, 95
— Public Health regulations for, xiv, 102
— sequelæ of, xiv, 93
— symptoms of, xiv, 85
— synonyms of, xiv, 80
— transmission of, iii, 20
— treatment of, iii, 22; xiv, 96
— vaccination and, xiv, 106
— — erythema multiforme following, xvi, 61
— variation in virulence of, iv, 129
— varieties of, xiv, 90
S. M. A. powder (synthetic milk), preparation of, xii, 40
Smear, blood, examination of, xi, 27
— — preparation of, xi, 26
— — staining of, xi, 26
Smell, early characteristics of, ii, 7, 115
— presence at birth, ii, 115
Smellie-Veit breech delivery, i, 118, 121
Smoking, pregnancy and, i, 24, 165
Sneezing, accessory nasal sinus disease and, ix, 28
— acute rhinitis and, ix, 5
— pollen fevers and, ix, 118
Snoring, adenoids causing, ix, 70
— tonsillectomy and, ix, 60
Snowflakes, pulmonary, x-ray in tuberculosis showing, ix, 232
Snuffles, adenoids and, ix, 71
— congenital syphilis causing, iii, 42
— diagnosis of hereditary syphilis and, xvii, 243
— non-luetic, iii, 77
— nursing hindered by, viii, 98
— syphilitic infants and, i, 75
— treatment of, ix, 15
Soaps, absorption of, x, 31
— digestion of, xii, 45
Soap-flake curds, ii, 93
Social service workers, maternity, i, 155, 174
Sodium, blood of newborn and, ii, 80
Sodium benzoate, sepsis neonatorum and, iii, 17
Sodium bicarbonate, acute follicular tonsillitis and, ix, 55
— adenoidectomy and, ix, 73
— nausea and, i, 25
— pregnancy and, convulsions in, i, 37
— pyelitis and, i, 36
— therapeutic use of, respiratory diseases and, ix, 261
— toxemia and, i, 131
Sodium bromid, tachycardia and, i, 33
Sodium chlorid test, renal function and, xix, 41
Sodium phosphate, pyelitis of pregnancy and, i, 36
Sodium salts, digestion and metabolism of, x, 40
Soft palate, actinomycosis of, viii, 40
Soft parts, gumma of, late inherited syphilis and, xvii, 164
Soft tissue, affections of, orthopedic management of, vi, 201
— peripheral nerve injuries affecting, vi, 251
Soldier's heart, xviii, 85
Sole print, identification by, ii, 126
Solids, blood, newborn, ii, 74
Solitary chondroma, character of, vii, 160
Solitary osteoma, character of, vii, 160
Solitary renal cyst, xv, 365
— incidence of, xix, 13
Songs, health, hygiene and, iv, 100
Sore-throat, epidemic, epidemiology of, ix, 44
— — etiology of, ix, 45
— — symptoms of, ix, 45
— — synonyms of, xiv, 308
— — treatment of, ix, 46
— recurrent, rheumatic infection causing, xviii, 67
— septic, milk transmission of, xii, 13
— — ulcerative stomatitis and, viii, 27
— streptococcus, ix, 44
— — milk as carrier of, xx, 122
Souffle, umbilical, fetal death in utero and, i, 50
Soup, caloric value of, x, 192
— diet of pregnancy and, i, 23
— normal child and, x, 124
— vegetable, bottle feeding supplemented by, xii, 134

Sour milk feeding, viii, 338
Soutter operations, tuberculosis of hip and, vi, 84
Spanking method at birth, i, 136
Spasm, esophageal, viii, 80
— habit, chorea differentiated from, xviii, 61
Spasmodic bronchitis, acute, ix, 109
Spasmodic croup, ix, 79
— diphtheria differentiated from, xiv, 168
Spasmodic laryngitis, diagnosis of, ix, 80
— etiology of, ix, 79
— symptoms of, ix, 79
— treatment of, ix, 81
Spasmodic nodding, v, 58
Spasmodic torticollis, tuberculosis of spine differentiated from, vii, 122
Spasmophilia, confirmatory signs of, x, 251
— convulsions and, iii, 246
— diagnosis of, x, 252
— etiology of, x, 248
— incidence of, x, 248
— prematurity and, ii, 172
— prognosis of, x, 252
— symptoms of, x, 249
— treatment of, x, 252
Spastic cerebral paralysis, diagnosis of, vi, 239
— etiology of, vi, 237
— general considerations of, vii, 246
— pathology of, vi, 238
— recognition of, v, 143
— symptoms of, vi, 238
— treatment of, vi, 240
Spastic paraplegia, Erb's, neurosyphilis and, xvii, 207
— obstetrical history of, i, 114
Spasticity, definition of, v, 2
— interpretation of, v, 151
Specific dynamic action, definition of, xiii, 13
Specific gravity, blood of newborn, ii, 65
— breast milk, ii, 145
— exudate and transudate differing in, ix, 197
— urine, age and, xiii, 41
Specific gravity, urine, diabetes insipidus and xiii, 86
— — newborn, ii, 101
— — pregnancy and, i, 21
Specific therapy, methods of use of, respiratory diseases and, ix, 282
Speech, defects of, v, 195
— — delayed speech, v, 195
— — education and, v, 197
— inauguration of, iv, 66
— lenticular degeneration and, v, 72, 74
— scanning, Friedreich's ataxia and, vi, 250
— subcortical lesion affecting, v, 143
Spermatic cord, torsion of, treatment of, xv, 271
Spermatozoön, syphilitic infection of, i, 64, 66, 67
Sphenoid sinus, examination of, ix, 25
Sphincter control, spina bifida occulta and loss of, v, 52
Spina bifida, anterior, clinical course of, xv, 212
— — clinical features of, xv, 211
— — differential diagnosis of, xv, 214
— — treatment of, xv, 214
— clinical classification of, vii, 47
— embryology of, xv, 206
— etiology of, vii, 48
— general considerations of, iii, 217, 282
— hereditary syphilis and, i, 67
— hydrocephalus and, v, 51; vii, 54
— Little's disease differentiated from, vi, 240
— operative treatment of, xv, 215
— prognosis of, vii, 48
— symptoms of, vii, 48
— treatment of, vii, 49
Spina bifida occulta, v, 51; xv, 208
— enuresis associated with, xix, 48
Spina ventosa, diagnosis of, vii, 133
— incidence of, vii, 132
— symptoms of, vi, 76
— syphilitic dactylitis differentiated from, vii, 151
— treatment of, vii, 133
Spinach, bottle feeding supplemented by, xii, 134
Spinal braces, vi, 42

Spinal canal, congenital defects and deformities of, shoulder-girdle deformities, vii, 49
— — spina bifida, vii, 47
— hemorrhage in, i, 118
Spinal column, contour and measurements of, vii, 8
— defects of, v, 50
Spinal cord, anatomy of, iii, 212
— attachments of, v, 34
— birth injuries of, v, 34
— — case history, v, 37
— development of, xv, 206
— diseases of, iii, 248
— hyperextension of spine injuring, v, 35
— icterus and, ii, 223
— injuries to, iii, 25
— — birth, i, 117, 118, 138, 150
— — breech delivery and, i, 8
— — gait in, v, 12
— — hemorrhages, i, 117, 120, 122
— — vertex delivery and, i, 117
— obstetrical injury of, v, 37
— regional symptoms of injury of, v, 35
— traction causing injury to, v, 34
— tuberculosis causing pressure on, v, 123
Spinal cord tumors, paraplegia caused by, v, 123, 127
— signs of, v, 121
— x-ray and opaque oil studies of, v, 122
Spinal fluid, bloody, newborn and, i, 120
— cerebrospinal meningitis and, xiv, 278
— colloidal gold reaction on, xvii, 55
— cytology of, xvii, 52
— globulin in, xvii, 54
— glucose in, xvii, 54
— laboratory examination of, xvii, 51
— — neurosyphilis and, xvii, 179
— neurosyphilis and clinical changes in, xvii, 186
— poliomyelitis and, xiv, 241, 242
— Wassermann reaction on, xvii, 51
Spinal meningitis, infantile, synonyms of, xiv, 224
Spinal myelitis, neurosyphilis and, xvii, 207
Spinal paralysis, acute, synonyms of, xiv, 224
Spinal puncture, newborn and, cerebral hemorrhage in, i, 138
— congenital syphilis and, i, 83
Spine, active motion of, vi, 24
— apparatus for treatment of, vi, 37
— application of cast to, vi, 41
— deformities of, congenital, vi, 292; vii, 50
— — hollow-back, vi, 269
— — round shoulders, vi, 269
— — scoliosis, vi, 260
— — spondylolisthesis, vi, 270
— development of, x, 58, 74; xv, 206
— fixation of, vi, 41
— fracture of, vi, 151
— orthopedic examination of, vi, 22
— osteochondritis of, vi, 114
— passive motion of, vi, 23
— physiological curves of, vi, 6, 22
— poliomyelitis and, vi, 218, 225
— — operative measures for, vi, 233
— range of motion of, vi, 20
— routine examination of, vi, 23
— tuberculosis of, Albee bone-graft operation in, vi, 93, 94
— — complications of, vi, 88; vii, 123
— — deformity in, vi, 87, 270
— — diagnosis of, vi, 91; vii, 122
— — dwarfism and, xiii, 152
— — etiology of, vii, 119
— — Hibbs' bone plasty and, vi, 94
— — history of, vii, 118
— — pathology of, vii, 119
— — perinephritic abscess differentiated from, xix, 176
— — prognosis of, vi, 92; vii, 123
— — rickets differentiated from, vii, 192
— — symptoms of, vi, 85; vii, 120
— — Taylor brace in, vi, 93
— — treatment of, vi, 92; vii, 123
— — x-ray examination for, vi, 90
— "typhoid", vi, 62; xiv, 199
Spirochæta morsus muris, neurosyphilis treated by inoculation with, xvii, 267

Spirochæta pallida, characteristics of, xvii, 18
— latent localization in testicle of, xvii, 68
— life in body tissues after death of host, xvii, 25
— liver and, i, 73-75
— neurotropism of, xvii, 182
— placenta and, i, 66, 68
— pregnancy and, i, 76
— strains of, xvii, 20
— syphilis transmission theories and, i, 64
Spleen, absence of, iii, 121
— anatomy of, ii, 121
— anemias associated with disturbances of, xi, 98
— Buhl's disease causing fatty degeneration of, iii, 4
— congenital anomalies of, iii, 121
— congenital syphilis, enlargement of, i, 73, 75; iii, 52; xvii, 245
— — pathology of, iii, 58
— development of, x, 67, 77
— diseases of, iii, 121
— injuries of, iii, 121
— malaria causing enlargement of, xiv, 212
— newborn, palpation of, ii, 135
— sepsis neonatorum causing enlargement of, iii, 14
— syphilis of, early manifestations of, xvii, 139
— — pathological evidence of, xvii, 29
— tuberculosis of, iii, 62; xiv, 355
— — relative frequency of, ix, 231
— typhoid pathology and, viii, 186
Splenic anemia, blood-picture of, xi, 100, 102, 106
— course of, xi, 112
— diagnosis of, xi, 111
— original description of, xi, 4, 5
— physical signs of, xi, 110
— primary, treatment of, xv, 335
— symptoms of, xi, 109
— treatment of, xi, 112
Splenomegaly, anemia with, xx, 58
— congenital syphilis and, iii, 48
— Still's disease and, vi, 52
— syphilitic, differential diagnosis of, iii, 53
Splenomyelogenous leukemia, epistaxis and, ix, 18
Splenunculi, iii, 121
Splints, contractures following brachial paralysis and, v, 31
— elbow, vi, 44
— peripheral nerve injuries and, vi, 251
— scar prevention and, vi, 203
— shoulder, vi, 43
— spine, vi, 41
— traction humerus, vi, 43
— Volkmann's paralysis and, vi, 211
— wrist, vi, 44
Splitting hair, xvi, 254
Splitting, skin, syphilitic infants and, i, 75
Spondylitis, acute infectious, diagnosis of, vi, 64
— — prognosis of, vi, 64
— — psoas abscess and, vi, 62
— — symptoms of, vi, 62
— — treatment of, vi, 66
— — tuberculosis of spine differentiated from, vi, 91
— — x-ray findings in, vi, 64
— acute traumatic treatment of, vi, 122
— chronic infectious, symptoms of, vi, 104
— complications of, vii, 123
— diagnosis of, vii, 122
— etiology of, vii, 119
— history of, vii, 118
— pathology of, vii, 119
— prognosis of, vii, 123
— symptoms of, vii, 120
— treatment of, vii, 123
Spondylolisthesis, etiology of, vi, 270
— examination of, vi, 271
— symptoms of, vi, 271
— treatment of, vi, 272
Sponge stick, placental lobules removed by, i, 92
Spontaneous subcutaneous emphysema, ix, 185
Spoon nails, xvi, 269
Spore of Malassez, xvi, 136
Sporotrichosis, blastomycosis differentiated from, xvi, 199
— diagnosis of, xvi, 201

Sporotrichosis, etiology of, xvi, 200
— pathology of, xvi, 200
— prognosis of, xvi, 201
— symptoms of, xvi, 199
— treatment of, xvi, 201
Sports, metabolism and activities during, xiii, 5
Spotted fever, synonyms of, xiv, 265
Spotted typhus, synonyms of, xiv, 265
Sprain, ankle, vi, 118
— elbow, vi, 122
— hip, vi, 120
— knee, vi, 119
— sacro-iliac joint, vi, 120
Sprengel's deformity, iii, 283; vii, 49
Sputum, bacteriology of, xx, 85
— macroscopic examination of, xx, 84
Squint, brain tumors causing, v, 118
— tentorial tear with hemorrhage causing, v, 46
Stabil's dry goat's milk powder, composition of, xii, 20
Staining, blood, placenta prævia and, i, 58
— — pregnancy and, 47, 50, 169
— oxidase, xi, 29
— pioneer work in, xi, 2
— vital, purpose and technic of, xi, 29
Stains, blood, special, xx, 41
Stammering, management of, v, 197
Standard (basal) metabolism, body surface and, xiii, 10
— conditions required for determining, xiii, 3
— "cost of digestion", xiii, 3
— definition of, xiii, 2
— fever and, xiii, 5
— formula for newborn rate of, xiii, 7
— growth and, xiii, 6
— height and, xiii, 8
— muscular activity and, xiii, 4
— sex and, xiii, 12
— weight and, xiii, 10
Standards of successful nursing, xii, 184
Stanford revision of Binet tests, iv, 78; v, 157
Staphylococcus, acute infectious arthritis and, vi, 50
— infection of fetus by, ii, 10
Staphylococcus epidermidis albus, xv, 136
Staphylococcus meningitis, cerebrospinal fluid in, xx, 111
Staphylococcus pyogenes, skin diseases due to, xvi, 203
Staphyloma, anterior, iii, 361
Starches, xii, 40, 42
— digestion of, x, 34; xii, 49
— — injury from, viii, 164
— formula changes involving, xii, 85
— intestinal digestion of, viii, 142
— raw, feeding of, xii, 131
Starchy foods, diet of pregnancy and, i, 165
Starvation, actual cause of death in, x, 215
— age and endurance of, x, 204
— blood-sugar and, xx, 163
— eclampsia and, i, 39
— epilepsy treated by, v, 139
— immediate effects of, x, 209
— ketosis caused by, xx, 170
— labor and, i, 130
— period of endurance of, x, 207
— psychology of infancy and, xii, 153
— ultimate results of, x, 199
Starvation fever, newborn and, viii, 101
Starvation stools, character of, xx, 72
Stasis, gastric, vomiting and, xii, 115
— pulmonary, hypostatic pneumonia following, iii, 85
— renal, symptoms of, xix, 128
State requirements, midwifery, i, 152, 153
Static affections, orthopedic, vi, 49
Static deformities, hollow-back, vi, 269
— orthopedic management of, vi, 256
— round shoulders, vi, 269
— scoliosis, vi, 260
— spondylolisthesis, vi, 270
— visceroptosis, vi, 272
— weak foot, vi, 257
Static peritonitis, viii, 262
Statistics, newborn mortality, value of, ii, 3, 121
Stature, age and proportionate, x, 79, 86
— biological factors affecting, x, 8
— caloric value, x, 214

Stature, cell factors determining, x, 42
— inanition affecting, x, 204
— inanition and, x, 206
— racial influence of food on, x, 2, 9
— rickets and, x, 239
— seasonal factor in, x, 89
— vitamins affecting, x, 214
Status lymphaticus, incidence of, xiii, 90
Status tetany, vii, 196
Status thymicolymphaticus, iii, 376
— surgery and, xv, 204
Steam, acute bronchitis and, ix, 105
— bronchopneumonia and, ix, 135
Steapsin, ii, 89
Stearate of zinc aspiration of, xv, 244
Stearic acid, ii, 47
Steatorrhea, iii, 176
Steinke splint, arm fractures of the newborn and, i, 124
Stenosis, aortic, diagnosis of, xviii, 198
— — pathological physiology of, xviii, 46
— — physical signs of, xviii, 122
— colon, cause of, iii, 145
— — diagnosis of, iii, 149
— — pathology of, iii, 146
— — prognosis of, iii, 150
— — symptoms of, iii, 148
— — treatment of, iii, 151
— congenital hypertrophic pyloric, clinical features of, xv, 285
— — diagnosis of, xv, 288
— — incidence of, xv, 283
— — operative treatment of, xv, 292
— — treatment of, xv, 290
— congenital pyloric, iii, 139
— — symptoms of stasis and retention caused by, xii, 115, 189
— — treatment of, iii, 143
— esophageal, treatment of, xv, 275
— gall-duct, syphilis causing, iii, 58
— hypertrophic pyloric, diagnosis and differentiation of, viii, 119
— — etiology of, viii, 114
— — incidence of, viii, 114
— — nomenclature and history of. viii, 113
Stenosis, hypertrophic pyloric, pathology and physiology of, viii, 115
— — prognosis of, viii, 117, 124
— — symptoms of, viii, 113, 115
— — treatment of, viii, 121
— — — surgical, viii, 123
— intestinal, diagnosis of, viii, 236
— — symptoms of, viii, 235
— — treatment of, xv, 275
— laryngeal or tracheal, iii, 70
— meatal, congenital, xv, 354
— mitral, diagnosis of, xviii, 195
— — pathological physiology of, xviii, 44
— — physical signs of, xviii, 116
— pulmonic, anatomical considerations of, xviii, 133, 134
— — clinical considerations of, xviii, 139
— — electrocardiographic determination of, xviii, 184
— pyloric, malnutrition and, iv, 152
— small intestine, cause of, iii, 145
— — diagnosis of, iii, 149
— — pathology of, iii, 146
— — prognosis of, iii, 150
— — symptoms of, iii, 148
— — treatment of, iii, 151
— tricuspid, diagnosis of, xviii, 198
— — physical signs of, xviii, 46
Steppage gait, v, 13
Sterility, familial syphilis and, xvii, 96
— gonorrhea and, i, 61
— one-child, i, 6
Sterilization, tuberculous women and, i, 29
Sternum, congenital absence of, iii, 282; vii, 50
— tuberculosis of, treatment of, xv, 225
Stertorous respiration, significance of, ix, 89
Sthenic pneumonia, ix, 137
Stielchausten, synonyms of, xiv, 117
Stigmata, bone, latent syphilis and, xvii, 227
— congenital syphilitic, xvii, 39
— dental, syphilitic, xvii, 212
— latent syphilis and, xvii, 210

Stigmata, nerve, latent syphilis and, xvii, 226
— physical and mental, familial syphilis and, xvii, 106
— skin, latent syphilis and, xvii, 229
— syphilitic, clinical frequency of, xvii, 211
— — familial infection and, xvii, 106
— — ocular, xvii, 225
Stillbirths, autopsy of, i, 9
— breech deliveries and, i, 117
— causes of, i, 8
— Census reports, i, 2
— cerebral hemorrhage and, i, 112
— chondrodystrophy and, vii, 11
— frequency of, iv, 106
— history, patient's, i, 17
— prenatal clinics and, iv, 176
— reduction of, prenatal care and, i, 10, 12, 81, 82, 84
— spinal injuries and, i, 121
— syphilis and, i, 63, 64, 77, 79, 84; iii, 40
— — prenatal care and, i, 81, 82, 84
— tears of the falx and tentorium, i, 117
— traumatism at labor and, i, 111
Still's disease, acute rheumatic fever differentiated from, vii, 96
— course of, vi, 106; vii, 104
— diagnosis of, vii, 104
— etiology of, vii, 99
— infectious arthritis resembling, vi, 52
— nomenclature of, vii, 98
— pathology of, vii, 102
— polyarthritis and, vi, 105
— prognosis of, vii, 105, 107
— signs and symptoms of, vii, 103
— syphilis of bone differentiated from, vii, 151
— treatment of, vi, 107; vii, 106
Stimulants, x, 21
— therapeutic use of, respiratory diseases and, ix, 265
Stinging insects, xvi, 161
Stockings, infant, ii, 129
— pregnancy and, i, 162
Stoeffel operation, contractures relieved by, v, 145
— Little's disease and, vi, 241
Stoll, syphilis studied by, xvii, 8
Stomach, anatomy of, iii, 125; viii, 86
— atony of, viii, 94
— bacteria in, viii, 91
— capacity in infancy, viii, 87; xii, 54, 64
— contents of, information derived from examination of, xx, 89
— development of, x, 65
— digestion in, physiology of, viii, 89
— digestive function in infancy, viii, 88
— diseases and disturbances of, acute gastritis, viii, 104
— — acute toxic gastritis, viii, 106
— — atony of stomach, viii, 94
— — chronic gastric indigestion, viii, 107
— — cyclic vomiting, viii, 134
— — dilatation, viii, 108
— — foreign bodies, viii, 111
— — frozen milk causing, viii, 95
— — gastric insufficiency, viii, 94
— — gastro-enterospasm, viii, 126
— — hemorrhage, viii, 108
— — hypertrophic pyloric stenosis, viii, 113
— — intestinal influenza, viii, 95
— — malformations, viii, 113
— — mechanical vomiting, viii, 92
— — rumination, viii, 130
— — simple regurgitation, viii, 92
— — toxic vomiting, viii, 95
— — tumors, viii, 113
— — ulcer, viii, 109
— — vomiting in infancy, viii, 92
— — vomiting of central origin, viii, 95
— emptying time in infancy, viii, 87
— foreign bodies in, treatment of, viii, 112
— — variety of, viii, 111
— hemorrhage from, iii, 183
— hunger affecting, viii, 91
— lavage of, methods of, viii, 339
— malformations of, viii, 113
— neuralgic pains in, pregnancy and, i, 168
— newborn, iii, 125
— — absorption in, ii, 87

Stomach, newborn, capacity of, ii, 84; iii, 126
— — emptying time of, ii, 85
— — gastric juice secretion of, ii, 87
— — hunger contractions in, ii, 85
— — infection of, ii, 118
— physiology of, viii, 86, 89
— tuberculosis of, xiv, 352
— tumors of, viii, 113
— ulcer of, causes of, viii, 110
— — occurrence of, viii, 109
— — pathology of, viii, 110
— — symptoms of, viii, 111
Stomach-tube feeding, premature infant and, xii, 104
Stomatitis, iii, 188
— catarrhal, viii, 22
— etiology of, viii, 19
— follicular, viii, 24
— gangrenous, diagnosis of, viii, 33
— — etiology of, viii, 31
— — lesions of, viii, 32
— — nomenclature of, viii, 30
— — prophylaxis of, viii, 35
— — symptoms of, viii, 32
— — treatment of, viii, 34
— herpetic, diagnosis of, xvi, 342
— — etiology of, viii, 24; xvi, 342
— — prognosis of, xvi, 343
— — symptoms of, viii, 25; xvi, 342
— — treatment of, viii, 26; xvi, 342
— maculofibrinous, viii, 24
— mercurial, viii, 36
— ulcerative, viii, 26
— — diagnosis of, viii, 29
— — etiology of, viii, 27
— — lesions of, viii, 27
— — measles complicated by, xiv, 46
— — prophylaxis of, viii, 29
— — scarlet fever causing, xiv, 22
— — symptoms of, viii, 28
— — treatment of, viii, 29
— — Vincent's angina and, viii, 27
Stones, bladder, xix, 209
— — chronic pyelitis and, xix, 159
— intestinal, obstruction caused by, viii, 239
— kidney, diagnosis of, xix, 182
— — formation of, xix, 180
— — symptoms of, xix, 181
— — treatment of, xix, 182
Stones, salivary, viii, 58
— ureteral, chronic pyelitis and, xix, 159
— urinary, xv, 362
Stool, acid, alkalies for correction of, ix, 261
— blood in, viii, 144, 343
— fat in, viii, 143
— — infantilism with, viii, 206
— green irritating, breast feeding and, xii, 175
— incontinence of, enuresis and, xix, 58
— infantile, breast feeding and, viii, 143
— — feeding and, i, 145, 146
— — newborn, viii, 142
— intestinal indigestion and, xii, 119, 121
— newborn, bacteriology of, ii, 118
— — color of, ii, 137
— — frequency of, ii, 137
— — milk stools, ii, 91
— — soap-flake curds in, ii, 93
— normal, x, 97
— occult blood in, test for, viii, 343
— salt content of, viii, 144
— *See also* Feces.
Stories, bedtime, hygiene and, iv, 85
Stovarsol, treatment of syphilis with, xvii, 265
Strabismus, cerebrospinal meningitis and, xiv, 283
— internal, indications of, v, 149
Strain, pregnancy and, i, 168
Stramonium, asthma and, ix, 115
Stranguglioni, synonyms of, xiv, 141
Strawberries, contra-indicated in diet of pregnancy, i, 24, 165
Strawberry marks, xvi, 4
Strawberry-tongue, xiv, 15
Streptococcemia, postabortal hemolytic serum treatment and, i, 103
Streptococcus, acute infectious arthritis and, vi, 50
— animals infected with, horse serum and, i, 101
—hemolytic, scarlet fever and, iv, 136; xiv, 11
— infection of fetus by, iii, 10

Streptococcus, non-hemolytic, rheumatic heart disease caused by, xviii, 15

Streptococcus angina, synonyms of, xiv, 308

Streptococcus hæmolyticus, diffuse glomerular nephritis produced by injection of, xix, 25

Streptococcus infections, hemolytic, bacteriemia and, i, 103

— — intestinal, sepsis at labor due to, i, 5

— — serum treatment of, i, 101, 103

— non-hemolytic, puerperal infections with, i, 87

— — bacteriemia and, i, 93

— polyvalent serum treatment of, i, 99, 101, 103

— pregnancy and, bacteriemia in, i, 93

— — endometritis in, causes of, i, 95

— puerperal, i, 87

— — blood transfusion in, i, 104

— — symptomatology of, i, 93

—uterine, i, 89

— vaginal, percentages, i, 95

Streptococcus meningitis, cerebrospinal fluid in, xx, 111

— cerebrospinal meningitis differentiated from, xiv, 281

Streptococcus morbilli, measles and, xiv, 35, 56

Streptococcus mucosus, puerperal infections and, i, 87

Streptococcus peritonitis, viii, 263

Streptococcus pyogenenes, skin disease due to, xvi, 203

Streptococcus sore-throat, ix, 44

— milk as carrier of, xx, 122

— synonyms of, xiv, 308

Streptococcus viridans, endocarditis caused by, xviii, 186

— meningitis caused by, cerebrospinal fluid in, xx, 111

Stricture, esophageal, course of, viii, 81

— — diagnosis of, viii, 83

— — pathology of, viii, 80

— — symptoms of, viii, 81

— — treatment of, viii, 83

Stridor, congenital, cause of, iii, 72

Stridor, inspiratory laryngeal, iii, 72

— laryngeal, causes of, ix, 76

— thymic, iii, 75

Stroganoff treatment, convulsions of labor and, i, 38

Strophanthus, lobar pneumonia and, ix, 166

— stimulant use of, respiratory diseases and, ix, 266

Strophulus, xvi, 78

Structural anomalies, congenital, mental defectives and, v, 187

Strychnin, asphyxia neonatorum and, ii, 201

— cardiac weakness of arthritis deformans and, vii, 106

— lobar pneumonia and, ix, 166

— stimulant use of, respiratory diseases and, ix, 266

Strychnin poisoning, tetanus differentiated from, xiv, 301

Students, medical, obstetrical requirements of, i, 150

Study of mental disorders, methods of approach in, v, 153, 158, 171

Stupes, counterirritant use of, respiratory diseases and, ix, 257

Subacromial bursitis, orthopedic management of, vi, 217

Subacute appendicitis, diagnosis of, xv, 310

Subacute arthritic disease, course of, vii, 104

— diagnosis of, vii, 104

— etiology of, vii, 99

— nomenclature of, vii, 98

— pathology of, vii, 102

— prognosis of, vii, 105, 107

— signs and symptoms of, vii, 103

— treatment of, vii, 106

Subacute bacterial endocarditis, diagnosis of, xviii, 190, 199

— etiology of, xviii, 186

— prognosis of, xviii, 186, 190

— rheumatic carditis differentiated from, xviii, 186

Subacute osteomyelitis, treatment of, xv, 139

Subacute scurvy, x, 223

Subacute traumatic arthritis, characteristics of, vi, 123

Subarachnoid space, anatomy of, v, 111
— puncture of, v, 13
Subcortical extrapyramidal lesions, v, 143
Subcortical hemorrhage, cerebral palsy and, v, 149
Subcortical mechanisms, v, 3
Subcutaneous emphysema, treatment of, xv, 220
Subcutaneous fat, normal child's, x, 109
Subcutaneous nodules, rheumatic, xviii, 19, 69
Subdeltoid bursitis, vii, 264
Sublingual glands, anatomical and functional considerations of, viii, 52
— disturbances of secretion of, viii, 53
— inflammation of, viii, 58
Subluxation, bone, birth palsies and, i, 124
Submaxillary glands, anatomical and functional considerations of, viii, 52
— disturbances of secretion of, viii, 53
— inflammation of, viii, 58
Subnormal mentality, heredity and, iv, 9
Subpectoral injection, dehydration and, xiii, 43
Succus entericus, ii, 89
Sucking, mechanism of, viii, 2
Sucking pad, function of, viii, 1
Sucking reflex, ii, 115
Suckling, infection of mouth from, ii, 117
— physiology of, ii, 82
Sucrase, carbohydrate digestion by, x, 33
Suction, accessory nasal sinus disease and, ix, 36
— acute rhinitis and, ix, 7
— newborn, lines of, ii, 83
Sudamina, xvi, 276
Sugar, blood, inanition and reduced content of, xiii, 25
— — mongolism and, xiii, 158
— — newborn and, ii, 78
— breast milk, colic and, i, 145
Sugar, caloric requirement and, xii, 67
— cerebrospinal, normal, xx, 98
— diabetes mellitus and, xiii, 101, 102
— digestion of, xii, 48
— encephalitis and, v, 99
— feeding and, newborn, i, 142
— formula changes involving, xii, 85
— intestinal digestion of, viii, 142
— metabolism of, xiii, 13
— milk, ii, 146; xii, 40, 42
— prematurity affecting amount in blood, ii, 166
— relative values of, xii, 88
— shock prevention after labor and, i, 131
— tuberculous meningitis and, v, 97
— urine and, newborn, ii, 107
— — pregnancy, i, 21
Suggestion, convulsions and, v, 137
Sulpharsphenamin, treatment of syphilis with, xvii, 264
— ulceration stomatitis and, viii, 30
Sulphonal, dermatitis caused by, xvi, 48
Sulphur, dermatitis caused by, xvi, 42
— impetigo contagiosa and, iii, 327
— scabies and, iii, 347
Sumach, dermatitis caused by, xvi, 46
Summer camps, hygiene and, iv, 87
Summer clinics, child hygien and, iv, 170
Sunburn, treatment of, xvi, 38
Sunlight, artificial light compared with, vii, 219
— "canned," vi, 75
— composition of, vii, 217
— influence of local conditions on, vii, 218
— joint tuberculosis and, vi, 72
— leukocytosis caused by, xx, 42
— pathogenic microörganisms and, vii, 218
— plant life dependent upon, x, 202
— premature infant and, xii, 105
— rickets treated by, x, 245; xiii, 118
— salts and, xiii, 17
— tetany requiring, v, 135
— treatment of sepsis, i, 98
— value of, x, 25
Superficial reflexes, v, 11
Supernumerary ribs, xv, 188

Supernumerary toes, iii, 285
Supplementary feeding, iv, 50; xii, 174, 176
Supplies, labor and nursery, i, 170, 171
Suppositories, hygiene and, iv, 90
— use of, ii, 137
Suppurative meningitis, organisms causing, xx, 106, 112
Suppurative osteomyelitis, acute, acute epiphysitis type of, vii, 69
— — course of, vii, 69
— — etiology of, vii, 64
— — pathology of, vii, 65
— — symptoms of, vii, 68
Suppurative pericarditis, incidence of, xv, 244
Suppurative sialo-adenitis, acute, surgery of, xv, 188
Suppurative tenosynovitis, vii, 261, 263
Supracapsulin, stimulant use of, respiratory diseases and, ix, 266
Supracondylar fracture, humerus and, vi, 156
Suprarenal, malignant tumor of, vii, 150
— syphilis of, pathology of, xvii, 31
Suprarenal capsule, tuberculosis of, relative frequency of, ix, 231
Suprarenal cortex, tumors of, xiii, 95
Suprarenal gland, newborn, anatomy of, iii, 386
— — congenital syphilis and, iii, 59
— — diseases of, iii, 387
— — tumors of, iii, 389
Suprarenalin, stimulant use of, respiratory diseases and, ix, 266
Surface, body, area of, ii, 110
Surgery, pediatric, abdomen, xv, 272
— — abdominal contusions, xv, 296
— — abdominal tuberculosis, xv, 302
— — acidosis, xv, 24
— — acute cervical adenitis, xv, 189
— — acute intussusception, xv, 313
— — acute retropharyngeal abscess, xv, 178
— — acute suppurative sialo-adenitis, xv, 188
— — adhesion of clitoris and prepuce, xv, 355
— — adrenal tumors, xv, 369
Surgery, pediatric, alkalosis, xv, 26
— — anal fissure, xv, 345
— — appendicitis, xv, 305
— — back, xv, 206
— — blood diseases, xv, 50
— — bone diseases, xv, 118
— — bone tuberculosis, xv, 140
— — bone tumors, xv, 125
— — branchial cysts, xv, 183
— — branchial fistulæ, xv, 184
— — Brodie's abscess, xv, 139
— — burns and scalds, xv, 15
— — cellulitis of neck, xv, 191
— — cervical auricles, xv, 188
— — cervical ribs, xv, 188
— — chest, xv, 218
— — choice of anesthetic, xv, 29
— — circumcision, xv, 353
— — clinical examination in, xv, 3
— — congenital hypertrophic pyloric stenosis, xv, 283
— — congenital kidney anomalies, xv, 364
— — congenital sacrococcygeal sinuses and fistulæ, xv, 217
— — congenital syphilis, xv, 46
— — congenital tongue-tie, xv, 174
— — cystic hygroma, xv, 197
— — cysts of face, xv, 173
— — dehydration, xv, 22
— — developmental bone disease, xv, 119
— — developmental errors of gastrointestinal tract, xv, 272
— — diaphragmatic hernia, xv, 247
— — empyema, xv, 225, 231
— — enteric cysts, xv, 339
— — epididymis and testis, xv, 371
— — epigastric hernia, xv, 266
— — epispadias, xv, 359
— — ether administration, xv, 30
— — eventration of diaphragm, xv, 253
— — exstrophy of bladder, xv, 357
— — face and mouth xv, 166
— — femoral hernia, xv, 265
— — fistula in ano, xv, 348
— — foreign bodies in chest, xv, 240
— — fractures and epiphyseal separations, xv, 66
— — general considerations of, xv, 1

Surgery, pediatric, goiter, xv, 200
—— harelip and cleft-palate, xv, 166
—— head, xv, 151
—— hemangiomata, xv, 57
—— hemolytic jaundice, xv, 54
—— hemophilia, xv, 53
—— hemophilic or bleeder's joint, xv, 149
—— hemorrhoids, xv, 348
—— hernia, xv, 256
—— hydrocele, xv, 266
—— hypospadias, xv, 355
—— imperfectly descended testis, xv, 267
—— inguinal hernia, xv, 259, 263
—— injuries of chest, xv, 218
—— intestinal obstruction, xv, 320
—— jaundice in sepsis of newly born, xv, 311
—— jaw, xv, 181
—— joint diseases, xv, 144
—— liver and bile-ducts, xv, 330
—— lung abscess, xv, 236
—— lymphangiomata, xv, 62
—— macroglossia, xv, 175
—— macrostomia, xv, 173
—— malformations of anus and rectum, xv, 341
—— mastitis, xv, 221
—— mediastinitis, xv, 246
—— megacolon, xv, 322
—— neck, xv, 183
—— omental and mesenteric cysts, xv, 338
—— Osgood-Schlatter's disease, xv, 141
—— osteomyelitis, xv, 129, 137
—— perianal and ischiorectal abscess, xv, 347
—— peritonitis in newborn, xv, 298
—— peritonsillar abscess, xv, 180
—— phimosis, xv, 352
—— postoperative care, xv, 31
—— precautions during operation, xv, 30
—— preoperative care, xv, 28
—— prolapse of rectum, xv, 345
—— pyelitis, xv, 359
—— quinsy, xv, 180
—— ranula, xv, 176
—— rectal polyp, xv, 344
Surgery, pediatric, rectum and anus, xv, 341
—— renal cysts, xv, 364
—— retroperitoneal abscess, xv, 311
—— rickets, xv, 41
—— sacrococcygeal tumors, xv, 215
—— sarcoma of intestine, xv, 339
—— scurvy, xv, 34
—— shock, xv, 23
—— spina bifida, xv, 206, 215
—— splenic anemia and Gaucher's disease, xv, 335
—— suppurative pericarditis, xv, 244
—— synovitis and arthritis, xv, 146
—— thymus, xv, 203
—— thyroglossal cysts and fistulæ, xv, 185
—— thyroid, xv, 200
—— torsion of spermatic cord, xv, 271
—— transfusion, xv, 32
—— tuberculosis of cervical glands, xv, 192
—— tuberculosis of kidney, xv, 365
—— tuberculosis of ribs and sternum, xv, 225
—— tumor incidence, xv, 56
—— tumors of breast, xv, 225
—— tumors of kidney, xv, 366
—— tumors of mediastinum, xv, 247
—— tumors of ovary, xv, 337
—— tumors of testis, xv, 372
—— ulcers of frenum, xv, 175
—— umbilical affections, xv, 281
—— umbilical hernia, xv, 256
—— urinary lithiasis, xv, 362
—— ventral hernia, xv, 265
—— Vincent's angina, xv, 180
—— wounds of soft parts and, xv, 9
Surgical shock, labor and, i, 133
Surgical tuberculosis, Rollier's heliotherapy technic applied to, vii, 223
Susceptibility, protein allergy, viii, 317
Susceptibility and immunity, later infancy and childhood and, xii, 140
Sutures, repair of lacerations and, i, 89
Swamp fever, synonyms of, xiv, 209
S wave, significance of, ii, 60

Sweat glands, diseases of, anidrosis, xvi, 276
— — bromidrosis, xvi, 275
— — chromidrosis, xvi, 276
— — granulosis rubra nasi, xvi, 278
— — hematidrosis, xvi, 276
— — hyperidrosis, xvi, 274
— — miliaria, xvi, 277
— — sudamina, xvi, 276
Sweats, night, tuberculosis and, ix, 229
— temperature regulated by, ii, 109
— weight loss due to, ii, 109
Sweetened condensed milk, composition of, xii, 34
Sweets, caloric value of, x, 193
— diet of pregnancy and, i, 165
Swelling, extremities and, i, 94, 168
Swift's disease, diagnosis of, x, 280
— etiology of, x, 276, 278
— pathology of, x, 278
— symptoms of, x, 277
— treatment of, x, 281
Sylvius, tuberculosis recognized by, ix, 216
Symelia, anatomy of, vii, 58
Symmetrical gangrene, xvi, 299
— late inherited syphilis and, xvii, 170
Sympathetic ramisection, v, 145
Symphalangism, iii, 286
Symptomatic non-thrombopenic purpura, case history of, xi, 210
— diagnosis of, xi, 211
— etiology of, xi, 209
— treatment of, xi, 212
Symptomatic purpura, blood changes in, xx, 53
— surgical aspects of, xv, 51
— symptoms of, xvi, 69
Symptomatic thrombopenic purpura, case history of, xi, 201
— diagnosis of, xi, 203
— treatment of, xi, 204
Syndactylism, heredity and, iv, 8
— latent syphilis and, xvii, 231
Synechia cordis, iii, 118
Synostosis, radio-ulnar, iii, 287
Synovial membrane, tuberculosis causing changes in, vii, 114
Synovitis, acute, vii, 83
Synovitis, acute infective, pathology of, xv, 145
— — treatment of, xv, 146
— acute non-infectious, vii, 86
— acute traumatic, vii, 86
— allergic, vii, 88
— cerebrospinal meningitis and, xiv, 282
— chronic, vii, 83
— syphilitic, vii, 98; xv, 49
— traumatic, clinical features of, xv, 144
— — treatment of, xv, 145
Synthetic milk (S. M. A. powder), preparation of, xii, 40
Syphilis, abortions and stillbirths ascribed to, iii, 40
— acquired, congenital syphilis and, iii, 38
— — lupus vulgaris differential from, xvi, 228
— — newborn and, iii, 38
— — pathology of, xvii, 41
— — prognosis of, xvii, 257
— — results of treatment of, xvii, 284
— adult manifestations differentiated from those in child, xvii, 2
— alimentary hemorrhage and, iii, 182
— alopecia due to, xvi, 256
— anemia and, xvii, 139
— anemia caused by, xi, 72; xx, 50
— antenatal mortality and, iv, 107
— arsenicals in treatment of, xvii, 262
— bismuth in treatment of, xvii, 266
— blastomycosis differentiated from, xvi, 199
— blood changes in, xvii, 43; xx, 48
— blood-count in, xi, 53
— blood-vessel, pathology of, xvii, 37
— bone, destructive stage of, vi, 138
— — diagnosis of, vi, 139
— — Garré's sclerosing osteomyelitis and, vi, 139
— — gumma formation in, vi, 98
— — incidence of lesions of, xvii, 131
— — late manifestations of, xvii, 153
— — osteochondritic form of, vi, 137
— — osteomyelitic form of, vi, 138
— — pathological evidence of, xvii, 26, 34
— — periosteal stage of, vi, 137

Syphilis, bone, prognosis of, vi, 139
— — symptoms of, vi, 136
— — treatment of, vi, 139
— — Wassermann test and, vi, 101
— bone and joint, vii, 135
— — diagnosis of, vii, 145
— — differential diagnosis of, vii, 149
— — early congenital lesions of, vii, 136
— — joint involvement in, vii, 148
— — late bone lesions, vii, 146
— — treatment of, vii, 151
— — tuberculosis of joints differentiated from, vi, 71
— breast feeding and, ii, 158
— cardiac, pathology of, xvii, 31, 37
— cerebral, epidemic encephalitis differentiated from, xiv, 261
— chorea and, xvii, 207
— chronic fibrosis of pancreas and, iii, 204
— Colles' laws of, xvii, 10, 64
— colloidal gold reaction on spinal fluid in, xvii, 55
— conceptional, i, 65, 66
— congenital, acquired syphilis and, iii, 38
— — bones and joints and, vi, 98
— — bone lesions in, i, 63, 70-73, 76; iii, 44
— — case report of, v, 82
— — clinical cures in, xvii, 253
— — clinical manifestations in diagnosis of, xvii, 242
— — congenital nephritis and, iii, 273
— — criteria of cure in, xvii, 256
— — definition of, xvii, 1
— — dermatitis-gangrenosa infantum differentiated from, xvi, 222
— — diagnosis of, iii, 51; xvii, 242
— — differential diagnosis of, iii, 52
— — drugs used in treatment of, xvii, 259
— — dwarfism and, xiii, 153
— — ear conditions due to, i, 76
— — eczema seborrheicum differentiated from, xvi, 137
— — eye conditions due to, i, 76
— — feeding and, iii, 57
— — kidney involvement by, iii, 273
Syphilis, congenital, laboratory tests in diagnosis of, xvii, 242
— — microscopic findings in, iii, 49
— — mortality due to, i, 64, 65, 77; ii, 3, 6
— — outline for treatment of, xvii, 258
— — pathology of viscera and central nervous system in, iii, 58
— — pemphigus neonatorum differentiated from, xvi, 213
— — pemphigus vulgaris differentiated from bullous lesions of, xvi, 101
— — placenta and, iii, 50
— — pneumonia alba in, iii, 88
— — predisposing to hemorrhagic disease, ii, 231
— — prenatal care and, i, 14
— — prognosis of, xvii, 251
— — prophylaxis of, iii, 53; xvii, 258
— — pseudoparalysis of Parrot and, iii, 44
— — results of treatment of, xvii, 281
— — scurvy differentiated from, vii, 211
— — scurvy differentiated from periostitis of, xiii, 125
— — skin manifestations of, iii, 42
— — spastic cerebral paralysis and, vi, 238
— — special methods of treatment of, xvii, 266
— — spleen pathology in, iii, 58
— — spontaneous recovery in, xvii, 254
— — stigmata of, xvii, 39
— — surgical aspects of, xv, 46
— — symptomatic treatment of, iii, 57
— — symptoms of, iii, 41
— — teeth conditions due to, i, 76
— — test for, living child, i, 78
— — treatment of, i, 81, 83; iii, 53, 57; xvii, 258
— — Wassermann reaction in, iii, 50
— — x-ray findings in, iii, 46
— convulsions as a clinical manifestation of, xvii, 189
— cranial nerve, pathology of, xvii, 39
— degenerative nephritis associated with, xx, 152

Syphilis, diagnosis of, colloidal gold reaction in, xvii, 55
— early congenital postmortem diagnosis of, xvii, 33
— early hereditary, xvii, 1
— ecthyma differentiated from pustular lesion of, xvi, 210
— eczema differentiated from, xvi, 117
— Ehrlich's work on, xvii, 16
— encephalitic, pathology of, xvii, 38
— epilepsy and, xvii, 197
— erythema gluteale differentiated from, xvi, 35
— erythema hyperæmicum and, xvi, 57
— erythema nodosum differentiated from gummata of, xvi, 64
— etiology of, xvii, 18
— eye, early manifestations of, xvii, 137
— — late manifestations of, xvii, 144
— — pathology of, xvii, 35
— familial, effects of, xvii, 95
— — incidence of infection in, xvii, 100
— — morbidity incident to, xvii, 109
— — physical and mental stigmata from, xvii, 106
— — postnatal mortality in, xvii, 103
— — social aspects of, xvii, 110
— feeblemindedness and, v, 187
— fetal, i, 49
— — definition of, xvii, 2
— fetal death caused by, xvii, 98
— Fournier's work on, xvii, 11
— gumma of, erythema induratum differentiated from, xvi, 236
— — multiple abscesses of infants differentiated from, xvi, 219
— — pathology of, xvii, 33
— hemorrhage and, xvii, 138
— hereditary, i, 66-78
— — bulbo-medullary hemorrhages in, newborn and, i, 120
— — clinical manifestations in diagnosis of, xvii, 242
— — clinical cures in, xvii, 253
— — criteria of cure in, xvii, 256
— — diagnosis of, xvii, 242
— — drugs used in treatment of, xvii, 259
Syphilis, hereditary, involvement of nervous system in, xvii, 173
— — laboratory tests in diagnosis of, xvii, 242
— necrosis from, epiphyseal line, i, 72
— — outline for treatment of, xvii, 268
— — pathology of, i, 68
— — prognosis of, xvii, 251
— — prophylaxis of, xvii, 258
— — prevention the treatment of, iv, 146
— — results of treatment of, xvii, 281
— — special methods of treatment of, xvii, 266
— — spontaneous recovery in, xvii, 254
— — symptomatology of, i, 76
— — treatment of, xvii, 258
— historical considerations of, xvii, 3
— Hutchinson's work on, xvii, 11
— hydrocephalus and, v, 114; xvii, 188
— incidence of, among adults, xvii, 86
— — among men, xvii, 88
— — among women, xvii, 88
— — childhood and, xvii, 85, 90
— — familial, xvii, 100
— — in both sexes, xvii, 86
— — in colored race, xvii, 89
— infant mortality and, iv, 111
— infecting newborn, methods of, i, 64, 65, 66
— — spermatozoön, i, 64, 66, 67
— inherited, deafness and, xvii, 166
— — early lesions of, xvii, 112
— — early manifestations of, xvii, 112
— — late manifestations of, xvii, 141
— introspinal therapy of, xvii, 266
— iodids in treatment of, xvii, 262
— isolation of infants having, ii, 137
— joint, infections in, concomitant, vi, 101
— — diagnosis of, vi, 101
— — hip-joint tuberculosis differentiated from, vi, 82
— — late manifestations of, xvii, 149
— — pathology of, vi, 98; xvii, 35
— — prognosis of, vi, 102
— — Still's disease differentiated from, vii, 105
— — symptoms of, vi, 99

Syphilis, joint, treatment of, vi, 102
— — types of, vi, 99
— — Wassermann test in, vi, 101
— — x-ray examination of, vi, 100
— Kahn test in, relative value of Wassermann test and, xx, 69
— laboratory examination of blood in, xvii, 43
— laboratory examination of spinal fluid in, xvii, 51
— laryngeal, ix, 82
— late congenital, pathological evidence of, xvii, 33
— latent, bone stigmata of, xvii, 227
— — combination of stigmata in, xvii, 230
— — dental stigmata of, xvii, 212
— — incidence of, xvii, 208
— — nerve stigmata of, xvii, 226
— — resistance to reinfection in, xvii, 75
— — skin stigmata of, xvii, 229
— lingual, viii, 17
— liver, pathological evidence of, xvii, 28
— lung, early manifestations of, xvii, 140
— — incidence of, xvii, 168
— — pathological evidence of, xvii, 27
— lymph gland involvement in, xvii, 139
— macular lesion of, pityriasis rosea differentiated from, xvi, 139
— malnutrition and, iv, 153; xvii, 139, 245, 281
— maternal, influence on size of child, ii, 14
— maternal latent infection of, xvii, 69
— meningeal, pathology of, xvii, 38
— meningitis as a clinical manifestation of, xvii, 186
— mental deficiency and, xvii, 199
— mercury in treatment of, xvii, 260
— Metchnikoff's work on, xvii, 15
— mongolism and, xiii, 153
— morbidity incident to, xvii, 109
— nasal, ix, 15
— nephrosis and, xix, 80
— nervous sequelæ of, v, 81
— neuro-, chorea and, xvii, 207
Syphilis, neuro-, clinical diagnosis of, xvii, 249
— — clinical manifestations of, xvii, 185
— — convulsions as a clinical manifestation of, xvii, 189
— — cranial nerve involvement in, xvii, 196
— — criteria of diagnosis of, xvii, 174
— — eighth nerve involvement in, xvii, 197
— — epilepsy and, xvii, 197
— — general considerations of, xvii, 173
— — gumma of brain and, xvii, 206
— — hydrocephalus as a clinical manifestation of, xvii, 188
— — incidence of, xvii, 175
— — laboratory examination of spinal fluids in, xvii, 179
— — latent, xvii, 210
— — meningitis as a clinical manifestation of, xvii, 186
— — mental deficiency and, xvii, 199
— — optic atrophy in, xvii, 196
— — paralysis as a clinical manifestation of, xvii, 191
— — paresis and, xvii, 199, 202
— — pathology of, xvii, 31, 37
— — spinal myelitis and, xvii, 207
— — syphilitic dementia and, xvii, 199
— — tabes and, xvii, 205
— — tryparsamid treatment for late cases of, xvii, 269
— neurotropism in, xvii, 182
— non-specific treatment of certain lesions of, xvii, 281
— nursing and, iv, 48
— oral, viii, 17
— pancreatic, pathological evidence of, xvii, 29
— papulosquamous eruption of, psoriasis differentiated from, xvi, 129
— paralysis as a clinical manifestation of, xvii, 191
— parental infection with, xvii, 65
— paresis and, xvii, 199, 202
— paternal latent infection of, xvii, 68
— pathology of, xvii, 20

Syphilis, perléche differentiated from, xvi, 344
— permanent teeth and, viii, 69
— placental, xvii, 21
— placental transmission of, xvii, 70
— postconceptional, i, 65
— pregnancy and, i, 63-84
— — abortion and, i, 78
— — abruptio placentæ in, i, 52
— — drug administration in, i, 80
— — fetal death due to, i, 9, 48, 63
— — hemorrhage and, newborn, i, 138
— — incidence of, i, 77
— — infant death due to, i, 7, 63
— — maceration caused by, i, 49
— — prenatal care and, i, 12, 15, 84, 150
— — results of, i, 78-80
— — spontaneous cure of, i, 76
— — transmission and, i, 64-66
— — treatment of, i, 80-84
— — viscera and, infant, i, 73-75
— — Wassermann reaction and, i, 76-78
— prematurity caused by, ii, 163, 171; iii, 41
— prepubescent, introductory considerations of, xvii, 1
— prevention of, iv, 145
— relative value of Wassermann and Kahn tests in diagnosis of, xx, 69
— renal, xix, 192
— — early manifestations of, xvii, 140
— — pathological evidence of, xvii, 29
— responsibility for familial effects of, xvii, 95
— rheumatic infections and, xviii, 79
— rickets and, vii, 193
— Ricord's work on, xvii, 8
— salivary glands affected by, viii, 59
— Schaudinn's work on, xvii, 15
— skin, pathological evidence of, xvii, 27
— social aspects of, xvii, 110
— splenic, early manifestations of, xvii, 139
— — pathological evidence of, xvii, 29
Syphilis, sterility and, xvii, 96
— stigmata of, clinical frequency of, xvii, 211
— stillbirths and, iii, 40; xvii, 97
— suprarenal, pathology of, xvii, 31
— tabes and, xvii, 205
— telangiectasia in, xvi, 295
— temperature and, xvii, 139
— testicular, pathology of, xvii, 31
— transmission of, decreasing severity in, xvii, 75
— — effect of treatment during pregnancy on, xvii, 73
— — illustrative families, xvii, 79
— — infants and, xvii, 73
— — inheritance and, xvii, 63
— — maternal germ, xvii, 65
— — morbidity affected by, xvii, 109
— — parturition and, xvii, 72
— — paternal germ, xvii, 63
— — Profeta's law of immunity in, xvii, 74
— — second generation, xvii, 63
— — third generation, xvii, 77
— treatment of, drugs used in, xvii, 259
— — general considerations of, xvii, 258
— — intensive treatment given at intervals, xvii, 269
— — reactions following injections of arsphenamin in, xvii, 269
— — results of, xvii, 281
— — routine for ordinary cases, xvii, 268
— tuberculosis of bones and joints differentiated from, vii, 116
— visceral, incidence of, xvii, 168
— — pathology of, xvii, 37
— Wassermann reaction on blood in, xvii, 44
— Wassermann reaction on spinal fluid in, xvii, 51
— Wassermann's work on, xvii, 15
— Winckel's disease and, iii, 2
Syphilitic alopecia, incidence of, xvii, 124
Syphilitic arthritis, acute rheumatic fever differentiated from, vii, 96
— incidence of, xvii, 149

Syphilitic bone infection, diagnosis of, vii, 145
— differential diagnosis of, vii, 149
— early congenital lesions of, vii, 136
— joint involvement in, vii, 148
— late lesions of, vii, 146
— nature of, vii, 135
— treatment of, vii, 151
Syphilitic chorioretinitis, incidence of, xvii, 147
Syphilitic coryza, ix, 15
Syphilitic dactylitis, incidence of, xvii, 136
Syphilitic dementia, neurosyphilis and, xvii, 199
Syphilitic epiphysitis, incidence of, xvii, 131
Syphilitic facies, description of, xvii, 228
Syphilitic iritis, incidence of, xvii, 138, 149
Syphilitic joint infection, characteristics of, vii, 135
— diagnosis of, vii, 145
— differential diagnosis of, vii, 149
— symptoms of, vii, 148
— treatment of, vii, 151
Syphilitic keratitis, symptomatology of, xvii, 145
Syphilitic meningitis, cerebrospinal fluid in, xx, 103
— cerebrospinal lymphocytosis in, v, 15
— hydrocephalus caused by, v, 114
— vomiting and, viii, 95
Syphilitic nephritis, acute, blood chemistry in, xx, 147
Syphilitic optic neuritis, incidence of, xvii, 138
Syphilitic orchitis, xv, 372
— diagnosis of, xix, 218
— incidence of, xvii, 138
Syphilitic osteochondritis, acute, symptoms of, vii, 141
— incidence of, xvii, 131
Syphilitic osteoperiostitis, acute, case histories of, vii, 147
— incidence of, xvii, 154
— skull signs of, xvii, 137
Syphilitic paronychia, incidence of, xvii, 124
Syphilitic pemphigus, i, 75
— incidence of, xvii, 123
Syphilitic periostitis, incidence of, xvii, 134
Syphilitic pseudoparalysis, scurvy differentiated from, x, 226
Syphilitic rhinitis, diagnosis of, ix, 15
— incidence of, xvii, 124
— nursing hindered by, viii, 95
— symptoms of, ix, 15
— treatment of, ix, 15
Syphilitics, marital relations of, regulation of, i, 67, 81
Syringocystoma, description of, xvi, 28
Syringomyelia, dissociation of sensation in, v, 216
— progressive muscular atrophy differentiated from, vi, 247
Syringomyelocele, anatomy of, vii, 48
— spina bifida and, xv, 210
Systolic murmurs, pregnancy and, i, 30

Tabes dorsalis, Friedreich's ataxia differentiated from, vi, 250
— juvenile, cerebrospinal fluid in, xx, 104
— neurosyphilis and, xvii, 205
— rarity of, v, 81
Tâche cerebralé, lenticular degeneration showing, v, 74
Tachycardia, fear causing, iv, 71
— heart disease differentiated from, i, 33
— paroxysmal, electrocardiographic determination of, xviii, 181
— — rheumatic infections and, xviii, 82
Tænia echinococcus, xvi, 170
— lungs infested with, ix, 186
Tænia nana, morphology and identification of, xx, 82
Tænia saginata, intestinal infestation with, viii, 304
— morphology and identification of, xx, 80
Tænia solium, xvi, 170
— intestinal infestation with, viii, 304

Tænia solium, morphology and identification of, xx, 82
Talcum powder, use of, ii, 127
Talipes, description of, vi, 280
— diagnosis of, vi, 281
— orthopedic considerations of, vi, 280
— prognosis of, vi, 281
— treatment of, vi, 282
Talipes equinovarus, congenital, vii, 280
— treatment of, vii, 61
Tamponade, uterine, i, 29
— — abortion and, i, 48
— — abruptio placentæ, i, 32, 56
— — labor induction and, i, 110
— — placenta prævia and, i, 59, 60
Tannin, alimentary hemorrhage and, iii, 186
Tantrums, preventive pediatrics and, iv, 76
Tapeworm, xvi, 170
— intestinal infestation with, viii, 304
Tapping for cerebrospinal fluid, indications for, xx, 95
— technic of, xx, 96
Tar, dermatitis caused by, xvi, 42
Tarsal navicular bone, osteochondritis of, vii, 77
Tarsectomy, acute infectious arthritis necessitating, vi, 58
Taste, presence at birth, ii, 115
Tattoo marks, removal of, xvi, 286
Taurocholic acid, ii, 92
Taylor brace, spinal tuberculosis and, vi, 93
Tea, diet of pregnancy and, i, 165
— heart conditions and, i, 32
Teaching obstetrics, maternal protection and, i, 150
Tears, cervix, abortions and, i, 45
— — operative delivery and, i, 91
— — puerperal infections due to, i, 88, 91
— — repair of, i, 89, 97
— — ulcer in, i, 88
— falx, fetal death due to, i, 117
— forceps extraction, repair of, i, 89
— liability to, labor and, i, 96
— septum, breech deliveries with stillbirths and, i, 117
Technic, aseptic, labor and, i, 87
Tectospinal tract, v, 3
Teeth, bad, high blood-pressure and, i, 22
— care of, iv, 88
— — pregnancy and, i, 166
— carious, malnutrition and, iv, 160; x, 187
— congenital syphilis affecting, i, 76
— deciduous, abnormalities of, viii, 63
— — diseases of, viii, 63
— — disturbances during eruption of, viii, 62
— — eruption of, viii, 60
— — loss of, viii, 61
— — syphilitic stigmata of, xvii, 213
— development of, x, 56, 74, 77
— eruption of, iv, 31; x, 57, 73, 75, 76
— — nutrition indicated by, x, 106
— — vomiting in infancy and, viii, 94
— feeding and dentition, xii, 136
— foods for, viii, 70
— Hutchinson's, vii, 149; viii, 69
— — clinical description of, xvii, 215
— hygiene of, viii, 69
— infant, iv, 32, 88
— malocclusion of, malnutrition and, iv, 160
— newborn, breast feeding and, i, 140
— permanent, abnormalities of, viii, 65
— — caries of, viii, 66
— — eruption of, viii, 65
— — hygiene for, viii, 71
— — importance of first, iv, 89
— — malocclusion of, viii, 68
— — syphilitic stigmata of, viii, 69; xvii, 215
— — trauma of, viii, 68
— preschool age, iv, 32
— scurvy affecting development of, x, 222
— syphilitic stigmata of, xvii, 212
— — pathology of, xvii, 40
— tetany inaugurated by infection of, v, 135
Telangiectasia, general considerations of, iii, 334; xvi, 295
— hereditary hemorrhagic, xvi, 296
Telangiectatic bronchiectasis, iii, 93

Teleroentgenogram, size of heart determined by, xviii, 147
Temper tantrums, iv, 76
Temperature, amount of loss during delivery, ii, 49
— art of infant feeding and, xii, 145
— atmospheric, accessory nasal sinus disease and, ix, 36
— — acute laryngitis, and, ix, 78
— — adenoids and, ix, 68
— — asthma and, ix, 115
— — bronchopneumonia and, ix, 136
— — chronic bronchitis and, ix, 108
— — chronic rhinitis and, ix,
— — epistaxis and, ix, 19
— — lobar pneumonia and, ix, 162
— — nasal infections and, ix, 3
— average rectal, ii, 49
— bath, ii, 126
— body, ii, 48
— incubators and, ii, 179
— infancy and peculiarities in, xii, 140
— irregular, cause of, ii, 49
— nursery, ii, 50
— prematurity and, ii, 168
— prognostic value of, ii, 175
— puerperal infections and, i, 90, 93, 94
— puerperium and, i, 88
— pyelitis and, i, 35
— reaction of infant to, iv, 65
— rectal, ii, 49; ix, 283
— syphilis and, xvii, 139
Temperature taking, method of rectal, ix, 283
Temporal bone injury, facial paralysis and, i, 127
Temporary teeth, eruption of, x, 57, 75
Tendon reflexes, newborn, ii, 113
Tendons, affections of, orthopedic management of, vi, 49, 215
— diseases of, ganglion, vii, 261, 264
— — tenosynovitis, vii, 261
— — thecitis, vii, 261
— malnutrition and, x, 178
— peroneal, displacement of, vi, 215
— surgery of, xv, 8
Tennis, pregnancy and, i, 25
Tennis elbow, vii, 265
Tennis elbow, orthopedic management of, vi, 217
Tenosynovitis, acute, vii, 261
— chronic, vii, 263
— orthopedic management of, vi, 215
Tenotomy, contractures from brachial paralysis and, v, 33
— pseudohypertrophic dystrophy and, v, 66
— relief of contractures by, v, 145
Tentorium cerebelli, hemorrhage following tear of, v, 46
— protection afforded by, v, 21
— rupture of, birth, i, 112, 113, 117, 121
— — facial paralysis and, i, 127
— — fetal death due to, i, 117
Tepid bath, therapeutic use of, respiratory diseases and, ix, 259
Teratoma, sacral, iii, 309
— sacrococcygeal, xv, 216
— thyroid, iii, 386
Teres minor, paralysis of, birth, i, 125
Tertian malaria, etiology of, xiv, 210
— temperature charts of, xiv, 213, 214
Test, mental, v, 154
Testes, descent of, xix, 19
— development of, xix, 3
— ectopic, etiological mechanism of, xix, 211
— — incidence of, xix, 211
— — treatment of, xix, 212
— inflammation of, xix, 216
— malignant tumor of, xix, 218
— mumps involving, xiv, 147
— newborn, anatomy of, iii, 259
— spirochetes localized in, xvii, 68
— syphilis of, xv, 48
— — diagnosis of, xix, 218
— — early manifestations of, xvii, 138
— — pathology of, xvii, 31
— tumors of, xv, 372
— undescended, xv, 269
— — cause of, xv, 267
— — clinical features of, xv, 268
Tetanus, antitoxin therapy of, xiv, 304
— bacteriology of, xiv, 296
— definition of, xiv, 296
— delayed, xiv, 300
— diagnosis of, xiv, 301
— differential diagnosis of, xv, 10

Tetanus, drug therapy in, xiv, 306
— history of, xiv, 296
— human carriers of, xiv, 296
— incidence of, xiv, 296, 301
— incubation period of, xiv, 299
— — prognosis and, xiv, 302
— leukocytosis in, xx, 48
— pathology of, xiv, 299
— prognosis of, xiv, 302
— prophylaxis of, xiv, 303; xv, 10
— Public Health regulations for, xiv, 307
— surgical treatment of, xiv, 305
— symptoms of, xiv, 299
— toxin of, xiv, 298
— treatment of, xiv, 303; xv, 11
— — surgical, xv, 9
— umbilical infection with, iii, 11
— vaccination complicated by, xix, 113
Tetanus neonatorum, cause of, iii, 32
— etiology and symptoms of, xiv, 301
— functional convulsive form, iii, 246
— general considerations of, xv, 10
— incidence of, iii, 31
— mortality of, iii, 32
— prophylactic treatment of, iii, 33
— symptoms of, iii, 32
— treatment of, iii, 33
Tetany, age factors in, v, 134
— alkalosis and, alkalosis due to medication, xiii, 38
— — gastric alkalosis due to loss of body chlorids, xiii, 36
— — infantile tetany, xiii, 37
— — parathyroid tetany, xiii, 36
— — respiratory alkalosis due to abnormal excretion of carbon dioxid, xiii, 37
— — symptoms of, xiii, 33
— anodal closing contraction in, v, 122
— anodal opening contraction in, v, 133
— blood changes in, xx, 175
— blood in, chemical constituents of, v, 135
— calcium content of blood in, v, 130
— corpopedal spasm and, v, 130
— cathodal closing contractions in, v, 132
— cathodal opening contraction in, v, 133
Tetany, Chvostek's sign in, v, 10, 131, 135; xiii, 34
— clinical signs of, xiii, 34
— cod-liver oil in, v, 135
— confirmatory signs of, x, 251
— convulsions and, iii, 246; v, 130
— — infancy and childhood and, xii, 141
— diagnosis of, x, 252
— electrical hyperexcitability in, v, 131
— Erb phenomenon in, xiii, 35
— etiology of, x, 248
— foci of infection precipitating, v, 135
— hyperexcitability by electrical current in, v, 131
— hypoparathyroid, symptoms of, xiii, 72
— — treatment of, xiii, 73
— incidence of, x, 248
— infantile, xiii, 37
— — cerebrospinal meningitis differentiated from, xiv, 281
— — oral administration of HCl in, xx, 90
— infection and, v, 135
— laryngospasm and, v, 130
— parathyroid, xiii, 36
— peripheral nerve excitability increased by, v, 130
— prognosis of, x, 252
— quartz lamp therapy in, v, 135
— rickets and, v, 130; vii, 194
— sunlight in, v, 135
— symptoms of, v, 130; x, 249
— tetanus differentiated from, xiv, 301
— treatment of, x, 252
— Trousseau's sign in, v, 10, 130; xiii, 35
Thecitis, acute, vii, 261
— chronic, vii, 263
— tuberculous, vii, 263
Therapeutic methods, respiratory diseases and, ix, 254, 267
— — actinotherapy in, ix, 260
— — counterirritants in, ix, 256
— — diet in, ix, 256
— — drug therapy in, ix, 261
— — heliotherapy in, ix, 260
— — hydrotherapy in, ix, 259
— — hygiene in, ix, 255

Therapeutic methods, respiratory diseases and, pharmaceutics in, ix, 261
— — psychotherapy in, ix, 255
Therapeutic shock, arsphenamin and, xvii, 279
Thermic fever, infancy and, viii, 102
Thermotherapy, acute infectious arthritis and, vi, 55
Thetford Mines Experiment, prenatal care and, i, 12
Thick feeding, viii, 337
Thiersch grafts, burns and scalds and, xv, 20
— scar contractures and, vi, 205
Thigh, fracture of, newborn and, i, 124
Third generation, transmission of syphilis to, xvii, 77
Thirst, sensation appearing early, ii, 116
Thomas caliper brace, tuberculosis of knee and, vi, 80
Thomas splint, vi, 30, 45
— application of, vi, 33
— coxa plana and, vi, 110
— description of, vi, 32
— femur fractures and, vi, 150
— hip-joint and, vi, 37
— knee and, vi, 31
— measurement for, vi, 32
— tuberculosis of hip and, vi, 84
— tuberculosis of knee and, vi, 80
Thomsen's disease, iii, 312
Thoracentesis, cyanosis and, ii, 206
— method of procedure in, ix, 284
— pleurisy with effusion and, ix, 197
— site of election in newborn, iii, 95
Thoracic duct, ix, 86
Thoracic index, fetal, iii, 69
Thorax, auscultation of, ix, 91
— auscultatory percussion of, ix, 97
— development of, x, 62, 74, 77
— inspection of, ix, 88
— measurements of, vii, 7
— newborn, anatomy of, iii, 69
— — bony anomalies of, iii, 282
— — circumference during first 12 days, ii, 33
— — diameter of, ii, 33
— — early diminution in size of, ii, 33
— — physiology of, iii, 70
Thorax, newborn, proportions of, ii, 28
— — size at birth, ii, 13, 23
— palpation of, ix, 90
— percussion of, ix, 94
— surgical, examination of, xv, 6
Thornwaldt's disease, ix, 73
Thread-worm, intestinal infestation with, viii, 304
Thrills, heart, significance of, xviii, 103
Throat, delayed speech due to anomalies of, v, 196
— secretions of, examination of, xx, 91
Throat irrigation, method of therapeutic use of, respiratory diseases and, ix, 285
Thrombi, multiple pulmonic, arsphenamin injections causing, xvii, 271
Thrombocytopenia, blood changes in, xx, 63
Thrombocytopenic purpura, essential, surgical aspects of, xv, 51
Thrombogen time of blood, xx, 37
Thrombopenic purpura, blood changes in, xx, 63
— idiopathic purpura hæmorrhagica, xi, 190
— secondary (symptomatic), xi, 190
— — case history of, xi, 201
— — diagnosis of, xi, 203
— — treatment of, xi, 204
Thrombophlebitis, operative treatment of, i, 104
— pyemia and, i, 94
— sepsis due to, i, 101
— staphylococcus causing, i, 93
— symptomatology of, i, 93
— visceral abscesses causing, i, 94
Thromboplastin, clotting and, ii, 232
Thrombosis, placental, cardiac cases and, i, 33
— — puerperal infections and, i, 89
— pulmonary, Winckel's disease and, iii, 2
— rheumatic fever complicated by, xviii, 39
— rheumatic infections and, xviii, 83
— sepsis neonatorum causing, iii, 13

Thrombosis, typhoid pathology and, viii, 186
— umbilical cord, fetal death and, i, 48
Thrush, iii, 190
— diagnosis of, viii, 21
— etiology of, viii, 19; xvi, 343
— lesions of, viii, 20
— prognosis of, viii, 22
— symptoms of, viii, 21; xvi, 343
— treatment of, viii, 22; xvi, 343
Thumb sucking, hygiene and, iv, 89
— psychology of infancy and, xii, 153
— vomiting caused by, xii, 114
Thymic asthma, iii, 75
— symptoms of, xiv, 88
Thymic stridor, iii, 75
Thymus gland, convulsions and enlargement of, v, 138
— decrease in size of, iv, 31
— development of, x, 69, 74
— disease involving, enlargement of thymus, xiii, 87
— — status lymphaticus, xiii, 90
— enlargement of, xiii, 87
— — cyanosis caused by, ii, 205
— hemorrhage of, syphilis differentiated from, i, 63
— hypertrophy of, thymoma differentiated from, ix, 212
— newborn, anatomy of, iii, 371
— — congenital syphilis and, iii, 59
— — cysts of, iii, 379
— — diseases of, iii, 372
— — enlargement of, i, 138; iii, 373
— — physiology of, iii, 372
— — tumors of, iii, 379
— surgery of, xv, 203
Thyroglossal cysts, diagnosis of, xv, 185
— treatment of, xv, 186
Thyroglossal duct, stridor following infection of, iii, 76
Thyroglossal fistulæ, xv, 186
Thyroid extract, intestinal care in, i, 25
— mongolism and, xiii, 161
— pollen fevers and, ix, 119
— pregnancy and, arhythmia of, i, 33
— tachycardia of, i, 33
Thyroid gland, cretinism and, v, 172, 192
Thyroid gland, development of, x, 69
— disease involving, cretinism, xiii, 53
— — exophthalmic goiter, xiii, 47
— — Graves', xiii, 47
— — hyperthyroidism, xiii, 47
— — hypothyroidism, xiii, 52
— — mild hypothyroidism, xiii, 70
— — myxedema, xiii, 66
— — physiological enlargement, xiii, 45
— — simple goiter, xiii, 45
— diuresis induced by, nephrotic edema treated by, xix, 93
— enlargement of, cyanosis caused by, ii, 205
— enuresis treated by administration of, xix, 58
— — functions of, xiii, 44
— inflammatory involvement of, xv, 200
— newborn, anatomy of, iii, 379
— — cysts of, iii, 386
— — diseases of, iii, 380
— — permanent enlargements of, iii, 382
— — stridor caused by enlargement of, iii, 76
— — teratoma of, iii, 386
— — transitory enlargements of, iii, 381
— — tumors of, iii, 386
— percentage of iodin in, iv, 125
— physiological enlargement of, xiii, 45
— tuberculosis of, xv, 200
Thyroprotein injection, nausea of pregnancy and, i, 25
Tibia, congenital anomalies of, vi, 278
— congenital curvature of, vii, 57
— epiphysitis of tubercle of, vi, 146
— fracture of, peripheral nerve injury and, vi, 252
— postpartum fracture of, xv, 112
— saber, typical appearance of, vii, 147
— scar contractures over, vi, 209
— subluxation of, tuberculosis causing, vi, 79, 80
Tibial tubercle disease, etiology of, vii, 77
— symptoms of, vii, 78
— treatment of, vii, 79

Ticks, xvi, 158
Tics or habit spasms, v, 206
Time tables, Gesell's, iv, 79; v, 49
Tinea cruris, xvi, 194
Tinea capitis, treatment of, xvi, 350
Tobacco, use of, pregnancy and, i, 1
Toenails, appearance at birth, ii, 13
Toes, clubbing of, xviii, 188, 199
Tolerance, alimentary dextrose, comparison of children and adults with regard to, xx, 159
— fat, xii, 46
Tollwut, synonyms of, xiv, 324
Tomato juice, antiscorbutic vitamin in, iv, 125
— bottle feeding supplemented by, xii, 131
— prematurity demanding, ii, 186
— scurvy treated by use of, x, 227
— vitamin content of, x, 23
Tone, muscle, control of, v, 1
— — malnutrition and deficiency of, iv, 150, 161
— — spasticity and, v, 151
Tongue, angioma of, viii, 4
— bifid, viii, 5
— black, xvi, 340
— congenital hypertrophy of, viii, 5
— cysts of, viii, 6
— deformities of, viii, 4
— double, viii, 5
— furrowed, xvi, 341
— geographic, viii, 15; xvi, 338
— grooved, xvi, 341
— inflammation of, viii, 16
— newborn, congenital angioma of, iii, 193
— — congenital anomalies of, iii, 130
— — congenital fissured, iii, 130
— — diseases of, iii, 188
— — hemorrhage of, iii, 182
— papilloma of, viii, 5
— prematurity affecting, ii, 164
— strawberry, scarlet fever and, xiv, 15
— surgery of, macroglossia, xv, 175
— — ranula, xv, 176
— syphilis of, viii, 17
— tumors of, viii, 4
Tongue-swallowing, viii, 4
Tongue-tie, iii, 130
Tongue-tie, anatomical considerations of, viii, 2
— congenital, treatment of, xv, 174
— operative management of, viii, 4
— treatment of, viii, 3
Tonics, chronic rhinitis and, ix, 12
— therapeutic use of, respiratory diseases and, ix, 267
Tonsillar diphtheria, viii, 40
Tonsillectomy, abscess of lung following, ix, 172
— complications resulting from, ix, 63
— heart disease and, xviii, 226
— indications for, viii, 50, 51; ix, 60
— peritonsillar abscess and, ix, 66
— recurrence after, ix, 60
— results of, ix, 63
— rheumatic infection and, xviii, 68
Tonsillitis, acute follicular, complications of, ix, 54
— — diagnosis of, viii, 47; ix, 53
— — diphtheria differentiated from, xiv, 168
— — etiology of, ix, 51
— — pathology of, ix, 51
— — prophylaxis of, ix, 54
— — scarlet fever differentiated from, xiv, 19
— — symptoms of, viii, 46; ix, 52
— — treatment of, viii, 47; ix, 54
— acute rheumatic fever and, xiv, 395
— chorea and, iv, 126
— chronic, character of cough of, ix, 99
— — etiology of, ix, 57
— — pathology of, ix, 57
— — symptoms of, ix, 58
— — treatment of, ix, 60
— chronic hypertrophic, ix, 57
— chronic lacumen, ix, 57
— chronic parenchymatous, ix, 57
— chronic rhinitis following, ix, 9
— cryptic, ix, 57
— hyperplastic, ix, 57
— hypertrophic, ix, 57
— phlegmonous, ix, 64
— rheumatic infection causing, xviii, 67
— scarlatinal, viii, 41
— ulceromembranous, diagnosis of, ix, 47

Tonsillitis, ulceromembranous, etiology of, ix, 46
— — treatment of, ix, 47
— Vincent's ulcerative, viii, 41
Tonsils, anatomy of, lymphoid disease affecting, viii, 48
— appearance at birth, iii, 67
— cardiac disease and, iv, 126
— chronic infectious arthritis and, vi, 105
— cysts of, ix, 66
— diseases of, acute follicular tonsillitis, viii, 46
— — acute tonsillitis, viii, 40
— — high blood-pressure and, pregnancy and, i, 22
— — malnutrition and, iv, 158; x, 187
— — peritonsillar abscess, viii, 42
— — pyelitis caused by, i, 36
— — scarlatinal tonsillitis, viii, 41
— — tonsillar diphtheria, viii, 40
— — Vincent's angina, viii, 41
— edema of, mumps causing, xiv, 148
— enlarged non-tuberculous bronchial glands and, ix, 211
— enucleation of, ix, 61
— faucial, acute follicular inflammation of, ix, 51
— — anatomy of, ix, 49
— — chronic inflammation of, ix, 57
— — function of, ix, 50
— hypertrophied, description of, ix, 50
— indications for removal of, ix, 60
— lingual, anatomy of, ix, 50
— — function of, ix, 50
— lymphoid disease causing anatomical changes in, viii, 48
— malformations of, iii, 76
— measles and, xiv, 40
— pharyngeal, anatomy of, ix, 49
— — function of, ix, 50
— — hypertrophy of, ix, 67
— radium treatment of, ix, 63
— removal of, indications for, viii, 50, 51; ix, 60
— — judgment required, iv, 159
— — methods of, ix, 61
— — results of, ix, 63
— — time for, ix, 61
— Roentgen therapy of, ix, 62
— tetany following infection of, v, 135
Tonsils, tuberculosis of, xiv, 350
— — relative frequency of, ix, 231
— x-ray treatment of, ix, 62
Top milk, composition of, xii, 24
Torcular Herophili, v, 22
Torsion, spermatic cord, treatment of, xv, 271
Torticollis, acute, vii, 237
— congenital, iii, 311
— — orthopedic considerations of, vi, 292
— spasmodic, tuberculosis of spine differentiated from, vii, 122
Tossferina, synonyms of, xiv, 117
Total acidity, gastric juice, newborn, ii, 87
Total basal metabolism, inanition and, xiii, 25
Total nitrogen, ii, 102
Touch, presence in newborn, ii, 115
Toxemia, blood-pressure in newborn affected by, ii, 58
— burns and scalds and, xv, 16
— high fever with, heliotherapy contra-indicated in, ix, 260
— intestinal, convulsions and, xii, 142
— — erythema scarlatiniforme and, xvi, 59
— maternal deaths due to, i, 4, 5, 11
— nausea and vomiting in, i, 25
— placental separation and, i, 55
— pregnancy, i, 36-39
— abruptio placentæ and, i, 52
— acidosis with, i, 130-133
— chronic, high blood-pressure and, i, 22
— convulsions and, i, 10
— death in utero caused by, i, 107
— fetal death and, i, 9, 48
— intestinal care and, i, 25
— premature labor induction in, i, 107, 131
— prenatal care and, i, 10, 11, 15, 16, 36-39, 150
— puerperal infections due to, i, 91
— shock at labor caused by, i, 130, 131
— syphilis and, i, 75, 80
— urinary changes in, i, 37
— Wassermann reaction in, i, 76
Toxic conditions, early infant death due to, i, 7

Toxic conditions, heart and, i, 31
— maceration and, i, 49
— maternal breast milk and, i, 141
Toxic erythemas, xvi, 58
— synonyms of, xiv, 320
Toxic gastritis, acute, symptoms and treatment of, viii, 106
Toxic myositis, vii, 237
Toxic vomiting, infancy and, viii, 95
— treatment of, xii, 116
Toxin, erythema multiforme and, xvi, 62
— tetanus, xiv, 298
— virulence and, xiv, 3
Toxin-antitoxin, active diphtheria immunization with, iv, 133
— diphtheria, immunization with, xiv, 178
— — use of, xiv, 176
Trabeculation bladder, enuresis and, xix, 49
Trachea, anatomy of, ix, 84
— anomalies of, cyanosis caused by, ii, 205
— foreign bodies in, ix, 188
— lymphatics of, ix, 86
— newborn, anatomy of, iii, 68
— — diseases of, iii, 70
— — esophageal communication with, iii, 70
— — infections of, iii, 72
— — malformations of, iii, 70
— — normal development of, iii, 71
— — physiology of, iii, 68
Tracheal catheter, mucus removed with, ii, 124, 125
Tracheitis, acute, character of cough of, ix, 99
Tracheobronchial glands, enlarged, von Pirquet's skin test and, ix, 209
Tracheobronchitis, ix, 101
Tracheo-esophageal fistula, iii, 135
— cause of, iii, 137
Tracheotomy, acute laryngitis and, ix, 79
— diphtheria and, xiv, 173
Traction apparatus, fractures and, newborn, i, 124
Traction humerus splint, vi, 43
Training, art of infant feeding and, xii, 146
— parenthood, i, 3, 12, 15, 149-175
Transfusion, acute osteomyelitis and, xv, 136
— anemia and, xv, 51
— anemia secondary to infectious diseases and, xi, 77
— anemia secondary to malnutrition and, xi, 68
— blood, abruptio placentæ and, i, 56
— placenta prævia and, i, 60
— puerperal sepsis and, i, 103
— shock and, labor followed by, i, 134, 135
— blood-grouping for, xi, 30, 32
— chronic infectious diseases and, xi, 53
— compatibility tests and, ii, 73
— dehydration and, xv, 23
— exsanguination, erysipelas and, iii, 20
— glucose, icterus neonatorum and, ii, 226
— — shock and, labor followed by, i, 134
— hemophilia and, xi, 188
— idiopathic purpura hæmorrhagica and, xi, 200
— intracranial hemorrhage and, v, 44
— method of therapeutic use of, respiratory diseases and, ix, 286
— newborn and, xi, 181
— pediatric surgery and, dosage, xv, 33
— — indications, xv, 32
— — methods, xv, 33
— — precautions, xv, 32
Transillumination, accessory nasal sinus disease and, ix, 33
Transitional catarrh, ii, 119
Transitory fever, diagnosis of, ii, 211
— etiology of, ii, 208
— prognosis of, ii, 212
— temperature in, ii, 210
— treatment of, ii, 212
— weight loss in, ii, 210
Transmission of syphilis, i, 64-66
— decreasing severity in, xvii, 75
— effect of treatment during pregnancy on, xvii, 73

Transmission of syphilis, illustrative families, xvii, 79
— infants and, xvii, 73
— inheritance and, xvii, 63
— maternal germ, xvii, 65
— parturition and, xvii, 72
— paternal germ, xvii, 63
— Profeta's law of immunity in, xvii, 74
— second generation, xvii, 63
— third generation, xvii, 77
Transmission time, ii, 62
Transplantation, skin, scar treatment and, vi, 204
Transudates, examination of, xx, 92
— exudate differentiated from, ix, 197
Traub's space, pericardial effusion and, xviii, 126
Trauma, alimentary tract, iii, 186
— arachnoid adhesions following, v, 115
— birth, iii, 224
— — cerebral palsies and, v, 142
— — cerebrospinal fluid and, xx, 117
— — convulsions caused by, v, 129
— — deaths due to, i, 111
— — hemorrhagic disease and, ii, 228
— — infant mortality and, iv, 111
— — infection following, iii, 11
— — Little's disease and, vi, 237
— — mortality due to, ii, 3
— — nervous system affected by, v, 20
— cerebral palsy due to, v, 149
— chest, treatment of, xv, 218
— intracranial, v, 42
— intracranial hemorrhage and, iii, 233
— pachymeningitis hæmorrhagica interna caused by, v, 83
— permanent teeth and, viii, 68
— spinal cord, v, 34
Traumatic arthritis, acute, vii, 86
— — pathology of, vi, 118
— chronic, character of, vi, 123
— subacute, characteristics of, vi, 123
Traumatic bone affections, dislocations, vi, 177
— epiphyseal separations, vi, 166
— fractures, vi, 147
— — clavicle, vi, 161
— — elbow, vi, 156
Traumatic bone affections, fractures, femur, vi, 149
— — forearm, vi, 151
— — humerus, vi, 156
— — spine, vi, 151
— malunited fractures, vi, 169
— osteitis, vi, 181
— osteoporosis, vi, 181
— ununited fractures, vi, 174
Traumatic dermatitis, diagnosis of, xvi, 34, 35
— symptoms of, xvi, 34, 35
— treatment of, xvi, 34, 36
Traumatic myositis, Volkmann's, vii, 239
Traumatic myositis ossificans, clinical features of, xv, 124
Traumatic rhinitis, treatment of, ix, 17
Traumatic spondylitis, acute, treatment of, vi, 122
Traumatic synovitis, acute, vii, 86
— clinical features of, xv, 144
— treatment of, xv, 145
Tremor, cerebellar asynergia and, v, 12
— chronic encephalitis causing, v, 100
— globus pallidus lesions causing, v, 71
— lenticular degeneration showing, v, 74
— subcortical lesions causing, v, 143
Trench mouth, ulcerative stomatitis and, viii, 27
Trendelenburg's hip-muscle sign, vi, 16
Treponema pallidum, characteristics of, xvii, 18
— pregnancy and, liver in, i, 73-75
— — placenta in, i, 66, 68
— — syphilis transmission theories in, i, 64
— strains of, xvii, 20
— *See also* Spirochæta pallida.
Triceps reflex, newborn, ii, 113
Trichini spiralis, xvi, 171
— muscles affected by, vii, 237
Trichiniasis, vii, 237
Trichinosis, vii, 237
Trichocephalus dispar, intestinal infestation with, viii, 304

Trichocephalus dispar, morphology and identification of, xx, 79
Trichophyton, pompholyx and, xvi, 94
Trichophyton crateriforme, xvi, 175
Trichophyton ectothrix, xvi, 175
Trichophyton endothrix, xvi, 175
Trichorrhexis nodosa, etiology of, xvi, 254
— symptoms of, xvi, 254
— treatment of, xvi, 254
Trichotillomania, xvi, 255
Trichuris trichiura, intestinal infestation with, viii, 304
Tricuspid insufficiency, diagnosis of, xviii, 198
— physical signs of, xviii, 123
Tricuspid stenosis, diagnosis of, xviii, 198
— physical signs of, xviii, 46
Tricuspid valve, pathological physiology of, xviii, 45
Trilocular heart, iii, 105
Trismus, tetanous neonatorum and, iii, 32
Trousseau's sign, alkalosis and, xx, 174
— rickets and, vii, 186, 196
— tetany or spasmophilia and, v, 10, 130; x, 251; xiii, 35
True infantilism, diagnosis of, xiii, 146
— metabolism of, xiii, 145
— prognosis of, xiii, 147
— signs and symptoms of, xiii, 145
— treatment of, xiii, 147
Trunk, deformities of structure of, iii, 281
Trusses, inguinal hernia and, iii, 160
Tryparsamid, late neurosyphilis treated with, xvii, 269
— treatment of syphilis with, xvii, 264
Trypsin, newborn and, ii, 89
— — presence in meconium, ii, 92
— protein digestion by, x, 37
Tube feeding, viii, 338
Tubercle, true, study of, ix, 224
Tubercle bacillus, cultural characteristics of, ix, 217
— septicemia caused by, ix, 228
— staining of, ix, 218
— types of, ix, 217
Tuberculids, xvi, 236
— papulonecrotic, etiology of, xvi, 238
— — pathology of, xvi, 238
— — symptoms of, xvi, 238
— — treatment of, xvi, 239
Tuberculin, enuresis treated by injections of, xix, 58
— joint tuberculosis diagnosed by, vi, 71
Tuberculin skin test, intracutaneous, technic of, ix, 288
— von Pirquet, diagnostic value of, ix, 231; xiv, 336
Tuberculin test, cattle and, xii, 12
— tuberculous peritonitis and, viii, 283
— von Pirquet, technic of, ix, 287; xiv, 360
Tuberculoma, xiv, 348, 350
— cerebrospinal fluid in, xx, 103
Tuberculosis, abdominal, xv, 302
— — complications of, viii, 283
— — diagnosis of, viii, 282
— — etiology of, viii, 277
— — general survey of, viii, 276
— — intestinal lesions of, viii, 279
— — mesenteric lesions of, viii, 280
— — occurrence of, viii, 277
— — pathogenesis of, viii, 277
— — peritoneal lesions of, viii, 280
— — prognosis of, viii, 284
— — symptoms of, viii, 280
— — treatment of, viii, 284
— acute, early, acute osteomyelitis differentiated from, vii, 70
— acute miliary, typhoid fever differentiated from, xiv, 200
— adenoid, xiv, 350
— adrenal, xiv, 355
— age and, ix, 222, 230
— anemia caused by, xx, 50
— ankle, diagnosis of, vi, 76
— — syphilis differentiated from, vi, 76
— ankle and foot-joint, diagnosis of, vii, 130
— — symptoms of, vii, 130
— — treatment of, vii, 131
— appendical, xiv, 352
— artificial feeding and, ii, 150, 157
— blastomycosis differentiated from, xvi, 199

Tuberculosis, blood in, ix, 230
— bone, manifestations of, xv, 140
— — osteomyelitis differentiated from, vi, 133
— — scurvy differentiated from, vii, 212
— — symptoms and treatment of, vi, 136
— bone and joint, vii, 108; xiv, 356
— bovine and human types of bacillus of, relative frequency in humans, ix, 215
— brain tumors and, xiv, 348
— breast feeding prevented by, ii, 150
— bronchial gland, xiv, 341
— — diagnosis of, ix, 249
— — pathology of, ix, 247
— — physical signs of, ix, 248
— — symptoms of, ix, 248
— central nervous system and, xiv, 345
— cervical gland, xiv, 342; xv, 192
— — diagnosis of, ix, 246
— — pathology of, ix, 245
— — symptoms of, ix, 246
— — treatment of, ix, 247
— chronic pulmonary, diagnosis of, ix, 242
— — pathology of, ix, 241
— — prognosis of, ix, 243
— — symptoms of, ix, 242
— chronic ulcerative of lung, ix, 241
— classification of clinical manifestations of, ix, 233
— climate and, ix, 221
— cold abscesses of, multiple abscesses of infants differentiated from, xvi, 219
— constitutional inferiority and, ix, 223
— D'Espine's sign in, xiv, 341
— distribution of human and bovine types of, iv, 144
— diagnosis of, ix, 231; xiv, 340
— dietary treatment of, x, 196
— discovery of bacillus of, ix, 215
— ear, xiv, 349
— early inception of, ix, 215
— elbow-joint, vii, 131
— — management of, vi, 95
— emaciation and, ix, 230
Tuberculosis, endocrine disturbance and, ix, 223
— enteric, xiv, 352
— epididymal, xv, 371
— erythema nodosum and, xvi, 64
— etiology of, ix, 216; xiv, 337
— expectoration and, ix, 229
— eye, xiv, 348
— fever and, ix, 229
— finger, vii, 132
— foot, diagnosis of, vi, 76
— — syphilis differentiated from, vi, 76
— frequency of, ix, 218
— gastric, xiv, 352
— generalized, diagnosis of, ix, 235
— — incidence of, ix, 233
— — prognosis of, ix, 236
— — symptoms of, ix, 234
— genito-urinary, hematuria and, xix, 69
— heliotherapy in, xiv, 365
— hemoptysis and, ix, 230
— heredity and, ix, 221; xiv, 339
— hilus, ix, 247
— hip, coxa plana differentiated from, vi, 110
— — diagnosis of, vi, 82
— — differential diagnosis of, vii, 127
— — pathology of, vi, 81
— — prognosis of, vi, 83; vii, 127
— — psoas abscess differentiated from, vi, 82
— — symptoms of, vi, 82; vii, 125
— — treatment of, vi, 83; vii, 127
— history of, ix, 216; xiv, 332
— incidence in childhood, iv, 143
— infancy and, iv, 144
— intercurrent disease and, iv, 145; ix, 222
— intestinal, xv, 305
— — character of stools in, xx, 74
— introduction to the subject, xiv, 332
— joint, abscess complicating, vi, 76
— — clinical course of, vi, 70
— — complications affecting prognosis of, vi, 72
— — diagnosis of, vi, 70
— — etiology of, vi, 68
— — heliotherapy and, vi, 72
— — occurrence, vi, 69

Tuberculosis, joint, pathology of, vi, 69
— — prognosis of, vi, 71
— — Still's disease differentiated from, vii, 105
— — surgical treatment of, vi, 75
— — symptoms of, vi, 70
— — treatment of, vi, 72
— — — surgical, vi, 75
— — x-ray examination of, vi, 70
— joint and bone, vii, 108
— kidney, xiv, 355
— knee, diagnosis of, vii, 129
— — genu valgum caused by, vi, 78
— — pathology of, vii, 128
— — prognosis of, vi, 79; vii, 130
— — symptoms of, vi, 78; vii, 129
— — treatment of, vi, 80; vii, 130
— Koch's discovery of bacillus of, ix, 215
— laboratory methods, xiv, 359
— laryngeal, i, 27, 28; ix, 82; xiv, 350
— leukocyte count in, xx, 45
— liver, xiv, 354
— loss of weight by mother and nursing child indicative of, xii, 188
— lymphatic, ix, 244
— — cervical glands, ix, 245
— — hilus tuberculosis, ix, 247
— — mesenteric glands, ix, 250
— — tabes mesenterica, ix, 250
— malnutrition and, iv, 153
— maternal, size of child affected by, ii, 14
— measles and, iv, 145
— mesenteric gland, diagnosis of, ix, 250
— — symptoms of, ix, 250
— miliary, acute bronchitis differentiated from, ix, 104
— — diagnosis of, ix, 237
— — meningitis caused by, xiv, 344
— — prognosis of, ix, 237
— — symptoms of, ix, 236
— — types of, xiv, 355
— — typhoid fever and, viii, 192
— milk as carrier of, xx, 122
— modes of invasion of, ix, 219; xiv, 339
— nasal, xiv, 350
— natural predisposition to, ix, 220
Tuberculosis, nephrosis and, xix, 79
— nervous sequelæ of, v, 83
— newborn, breast milk and, iii, 63
— — placenta affected with, iii, 60
— night-sweats and, ix, 229
— nursing and, iv, 48
— organs affected by, relative table of, ix, 231
— pathology of, ix, 223
— patient's history and, i, 17
— perinephritic abscess differentiated from, xix, 176
— peritoneal, xiv, 353; xv, 303
— pharyngeal, xiv, 350
— predisposing factors, ix, 220
— predisposition of lung to, ix, 223
— pregnancy and labor and, i, 6, 18, 26-29
— prematurity caused by, ii, 163, 171
— prevalence of, ix, 218
— prevention of, iv, 142; xiv, 333
— primary mesenteric node, xiv, 343
— prophylaxis of, general, ix, 252
— Public Health regulations for, xiv, 372
— pulmonary, xiv, 350
— — acute bronchitis and, ix, 101
— — anemia secondary to, xi, 70
— — blood-count in, xi, 47
— — bronchopneumonia and, ix, 130
— — bronchopneumonia differentiated from, ix, 131
— — character of cough of, ix, 100
— — chronic phthisis, ix, 241
— — chronic pneumonia and, ix, 168
— — chronic pulmonary tuberculosis, ix, 241
— — chronic tuberculosis pneumonia, ix, 241
— — chronic ulcerative tuberculosis, ix, 241
— — cough as a symptom of, ix, 228
— — miliary, ix, 236
— — pleurisy with effusion caused by, ix, 195
— — tuberculous bronchitis, ix, 237
— — tuberculous bronchopneumonia, ix, 238
— — tuberculous pleurisy, ix, 243
— relative frequency as factor in orthopedic affections, vi, 50

Tuberculosis, relative mortality of heart disease and, xviii, 3
— renal, diagnosis of, xix, 190
— — heliotherapy contra-indicated in, ix, 260
— — incidence of, xix, 69, 188
— — pathology of, xv, 365
— — symptoms of, xix, 190
— — treatment of, xv, 366; xix, 191
— respiratory system, xiv, 350
— retroperitoneal, xv, 302
— ribs and sternum, xv, 225
— Rollier treatment of, xiv, 365
— scopolamin anesthesia in labor and, i, 29
— seat of lesion of, ix, 230
— serology of, xiv, 369
— sex and, ix, 222
— shoulder, management of, vi, 95; vii, 131
— skin, types of, xvi, 224
— sociological factors, ix, 222
— sources of infection, ix, 219; xiv, 338
— spine, Albee bone-graft operation in, vi, 93, 94
— — complications of, vi, 88; vii, 123
— — deformity in, vi, 87, 270
— — diagnosis of, vi, 91; vii, 122
— — etiology of, vii, 119
— — Hibbs' bone plasty and, vi, 94
— — history of, vii, 118
— — pathology of, vii, 119
— — pressure from, v, 123
— — prognosis of, vi, 92; vii, 123
— — rickets differentiated from, vii, 192
— — symptoms of, vi, 85; vii, 120
— — Taylor brace in, vi, 93
— — treatment of, vi, 92; vii, 123
— — x-ray examination for, vi, 90
— spleen, xiv, 355
— sputum in, characteristic appearance of, xx, 84
— surgical, Rollier's heliotherapy technic applied to, vii, 223
— symptomatology of, ix, 228; xiv, 340
— tonsillar, xiv, 350
— transmission of, ix, 219
— treatment of, i, 27; xiv, 362
Tuberculosis, treatment of, general, ix, 251
— — prophylactic, ix, 252
— true tubercle, description of, ix, 224
— upper extremity joint, vi, 95
— vaccination complicated by, xiv, 113
— vertebral, dwarfism and, xiii, 152
— whooping-cough aggravating, xiv, 124
— wrist-joint, vii, 132
— — management of, vi, 96
— x-ray diagnosis of, xiv, 361
Tuberculosis ulcerosa, xvi, 232
Tuberculosis verrucosa cutis, etiology of, xvi, 232
— pathology of, xvi, 232
— symptoms of, xvi, 231
— treatment of, xvi, 232
Tuberculous arthritis, vi, 68
— acute rheumatic fever differentiated from, vii, 96
— hereditary syphilis differentiated from, xvii, 247
Tuberculous ascites, treatment of, xv, 303
Tuberculous bone infection, bone-marrow changes in, vii, 114
— diagnosis of, vii, 115
— differential diagnosis of, vii, 116
— general considerations of, vii, 108
— incidence of human and bovine, vii, 109
— occurrence of, vii, 112
— pathology of, vii, 113
— portal of, vii, 111
— predisposing causes of, vii, 110
— prognosis of, vii, 117
— regional frequency of, vii, 113
— special areas affected by, vii, 118
— symptoms of, vii, 114
— treatment of, vii, 117
— types of organism causing, vii, 108
Tuberculous bronchitis, prognosis of, ix, 238
— symptoms of, ix, 237
Tuberculous bronchopneumonia, diagnosis of, ix, 240
— prognosis of, ix, 240
— symptoms of, ix, 238
Tuberculous dactylitis, vii, 132

Tuberculous dactylitis, syphilitic dactylitis differentiated from, vii, 151
Tuberculous diathesis, xiv, 339
Tuberculous empyema, treatment of, xv, 236
Tuberculous joint infections, cartilage changes in, vii, 114
— diagnosis of, vii, 115
— differential diagnosis of, vii, 116
— general considerations of, vii, 108
— incidence of human and bovine, vii, 109
— occurrence of, vii, 112
— pathology of, vii, 113
— portal of, vii, 111
— predisposing causes of, vii, 110
— prognosis of, vii, 117
— regional frequency of, vii, 113
— special areas affected by, vii, 118
— symptoms of, vii, 114
— synovial membrane changes in, vii, 114
— treatment of, vii, 117
— types of organism causing, vii, 108
Tuberculous meningitis, v, 96
— blood-sugar and, xx, 163
— breathing irregular in, ix, 88
— cerebrospinal fluid in, xx, 101
— cerebrospinal lymphocytosis in, v, 15
— cerebrospinal meningitis differentiated from, xiv, 280
— clotting of cerebrospinal fluid in, v, 16
— diagnosis of, xiv, 347
— epidemic encephalitis differentiated from, xiv, 261
— Froin's syndrome in, xx, 116
— hip-joint tuberculosis and, vi, 82
— incidence of, xiv, 345
— poliomyelitis differentiated from, xiv, 243
— prognosis of, vi, 71; xiv, 348
— protein and relative sugar concentration of cerebrospinal fluid in, xx, 102
— symptoms of, xiv, 346
— treatment of, xiv, 348
— vomiting and, viii, 95
Tuberculous orchitis, diagnosis of, xix, 217
— incidence of, xix, 216
— treatment of, xix, 217
Tuberculous osteomyelitis, syphilis differentiated from, vii, 150
Tuberculous pericarditis, xiv, 352
Tuberculous peritonitis, celiac disease differentiated from, viii, 214
— complications of, viii, 283
— diagnosis of, viii, 282
— lesions of, viii, 280
— prognosis of, viii, 284
— symptoms of, viii, 280
— treatment of, viii, 284
Tuberculous pleurisy, incidence of, ix, 243
— prognosis of, ix, 244
— symptoms of, ix, 243
Tuberculous pneumonia, chronic, diagnosis of, ix, 241
Tuberculous rhinitis, treatment of, ix, 16
Tuberculous thecitis, vii, 263
Tuberculous ulcers, xiv, 350
Tubes, fallopian, excision of, sterilization of the tuberculous and, i, 29
— — gonorrhea and, i, 61, 88, 94
— — puerperal fever and, i, 95
Tubular (parenchymatous) nephritis, acute, blood chemistry in, xx, 142
— — clinical features of, xix, 78; xx, 139
— *See also* Nephrosis.
— xix, 78. *See also* Nephrosis.
Tumor albus, diagnosis of, vii, 129
— pathology of, vii, 128
— prognosis of, vii, 130
— symptoms of, vii, 129
— treatment of, vii, 130
Tumors, abortion and, i, 43, 45
— adrenal, xiii, 94; xv, 369
— alimentary tract, iii, 193
— alveolar, xv, 181
— anemia secondary to, xi, 79
— bladder, symptoms of, xix, 208
— bone, iii, 309
— — benign, vi, 192; vii, 160; xv, 125
— — chondroma, vi, 193

Tumors, bone, endothelioma, vi, 199
— — frequency of, vii, 160
— — malignant, vi, 196; vii, 161
— — myeloma, vi, 200
— — osteochondroma, vi,
— — periosteal sarcoma, vi, 197
— — recurrent, vi, 196
— brain, iii, 250; v, 117
— — cerebrospinal fluid and, xx, 116
— — epidemic encephalitis differentiated from, xiv, 261
— — hydrocephalus and, v, 114
— — tuberculosis and, xiv, 348
— breast, diagnosis of, xv, 225
— — feeding prevented by, ii, 154
— bronchial, iii, 86
— cerebrospinal, hydrocephalus caused by, v, 114
— coccygeal, xv, 216
— genito-urinary, iii, 274
— hepatic, xv, 334
— hypertrophic pyloric spasm and, viii, 116
— incidence of, pediatric surgery and, xv, 56
— intraspinal, cerebrospinal fluid and, xx, 116
— joint, types of, vi, 125
— kidney, Wilms', xix, 183
— laryngeal, ix, 82
— lingual, viii, 4
— liver, iii, 200; viii, 325
— lung, iii, 86
— malignant, blood-count in, xi, 54
— — testicular, xix, 218
— maxillary, viii, 16
— mediastinal, iii, 96; xv, 247
— — diagnosis of, ix, 212
— — incidence and variety of, ix, 211
— — symptoms of, ix, 212
— — treatment of, ix, 214
— ovarian, i, 41, 42
— — diagnosis of, xix, 224
— — incidence of, xix, 223
— — prognosis of, xix, 224
— — treatment of, xv, 337
— parotid, viii, 53, 54
— pelvic, pregnancy and, i, 18, 41-44
— pineal gland, iii, 389
— — diagnosis of, xiii, 76
— — symptoms of, xiii, 74
Tumors, pineal gland, treatment of, xiii, 76
— presacral, xv, 216
— renal, clinical features of, xv, 367
— — diagnosis of, xv, 368
— — incidence of, xv, 366
— — treatment of, xv, 369
— sacral, congenital, iii, 309
— sacrococcygeal, surgery of, xv, 215
— salivary gland, iii, 199
— scalp, xv, 156
— testicular, xv, 372
— skin, iii, 346
— spinal cord, v, 121
— stomach diseases and, viii, 113
— suprarenal, iii, 389
— thymic, iii, 379
— thyroid, iii, 386
— umbilical, iii, 408; xv, 282
— vaginal, diagnosis of, xix, 224
— Wilms', diagnosis of, xix, 185
— — incidence of, xix, 183
— — symptoms of, xix, 184
— — treatment of, xix, 187
Tunica vaginalis, hydrocele of, xv, 266
Turnbuckle cast, scoliosis and, vi, 268
Turpentine, accidental poisoning with, viii, 314
Turpentine stupe, counterirritant use of, respiratory diseases and, ix, 257
T wave, meaning of, ii, 60; xviii, 166
Twilight sleep, ii, 123
Twin births, prematurity affecting mortality of, ii, 6
Twins, anemia in, xx, 50
— syphilis transmitted to, xvii, 71
Typho-Bacillose, ix, 228
Typhoid fever, acute infectious arthritis and, vi, 50
— acute osteomyelitis differentiated from, vii, 70
— age incidence of, viii, 184
— alopecia due to, xvi, 256
— anemia secondary to, xi, 69
— bacteriology of, xiv, 192
— blood-count in, xi, 47, 51
— breast feeding prevented by, ii, 150
— bronchopneumonia following, ix, 130
— carriers of, xiv, 206

Typhoid fever, complications of, viii, 190; xiv, 199
— course of, viii, 190
— definition of, xiv, 188
— descriptive summary of, viii, 184
— De Silvestri's color reaction in urine in, viii, 343
— diagnosis of, viii, 191
— diet and delirium in, x, 213
— differential diagnosis of, xiv, 200
— empyema and, ix, 201
— epistaxis in, ix, 18
— erythema hyperæmicum and, xvi, 57
— etiology of, viii, 185; xiv, 191
— fetal death and, i, 48
— heart complications in, xviii, 192
— herpes simplex and, xvi, 87
— history of, xiv, 188
— icterus index in, xx, 40
— incidence of, viii, 184; xiv, 190
— incubation period of, viii, 187; xiv, 193
— infection of fetus by bacillus of, iii, 10
— influenza differentiated from, xiv, 383
— leukopenia in, xx, 46
— malaria differentiated from, xiv, 218
— miliary tuberculosis and, viii, 191
— milk as carrier of, xii, 13; xx, 122
— newborn and, iii, 29
— pathological physiology of fever in, xiii, 39
— pathology of, viii, 185; xiv, 193
— plateau and step-ladder types of temperature in, viii, 187
— pneumonia and, viii, 191
— prematurity caused by, ii, 163
— prognosis of, viii, 194; xiv, 201
— prophylaxis of, viii, 194; xiv, 202
— Public Health regulations for, xiv, 207
— quarantine period in, xiv, 206
— relapse in, viii, 190
— rheumatic infections and, xviii, 79
— symptoms of, viii, 186; xiv, 194
— synonyms of, xiv, 188
— treatment of, viii, 192; xiv, 202, 204
Typhoid fever, tuberculin test negatived by, ix, 231
— vaccine therapy in, viii, 193
— Widal reaction in, viii, 342
Typhoid spine, xiv, 199
Typhoid vaccine, psoriasis and, xvi, 130
Typhus, spotted, synonyms of, xiv, 265
Typhus fever, blood-count in, xi, 47
— leukocyte count in, xx, 45
Tyrosin, presence in meconium, ii, 92
Tyrosinuria, significance of, xx, 19

Ulcer, alimentary tract, iii, 194
— esophageal, hemorrhage from, iii, 183
— frenal, simple, viii, 12
— — treatment of, xv, 175
— gastric, causes of, viii, 110
— — hemorrhage from, iii, 183
— — occurrence of, viii, 109
— — pathology of, viii, 110
— — symptoms of, viii, 111
— hard palate, viii, 35
— meatal, xv, 355
— Meckel's diverticulum and, viii, 246
— pterygoid, iii, 188
— puerperal, i, 88
— tuberculous, xiv, 350
Ulcerated meatus, treatment of, xix, 220
Ulcerative colitis, chronic, descriptive summary of, viii, 198
— — etiology of, viii, 198
— — lesions of, viii, 199
— — operative management of, viii, 202
— — symptoms of, viii, 199
— — treatment of, viii, 201
Ulcerative endocarditis, etiology of, xviii, 186
Ulcerative stomatitis, viii, 26
— diagnosis of, viii, 29
— etiology of, viii, 27
— lesions of, viii, 27
— measles complicated by, xiv, 46
— prophylaxis of, viii, 29
— scarlet fever causing, xiv, 22
— symptoms of, viii, 28
— treatment of, viii, 29

Ulcerative stomatitis, Vincent's angina and, viii, 27
Ulcerative tonsillitis, Vincent's, viii, 41
Ulcerative tuberculosis of lung, chronic, ix, 241
Ulceromembranous tonsillitis, diagnosis of, ix, 47
— etiology of, ix, 46
— treatment of, ix, 47
Ulna, postpartum fractures of, xv, 94
Ultraviolet lamps, types of, vii, 228
Ultraviolet rays, accessory nasal sinus disease and, ix, 37
— asthma and, ix, 116
— bone and joint diseases treated by, vii, 217
— chronic bronchitis and, ix, 108
— effects on body of, x, 25
— leukocytosis caused by, xx, 42
— milk preparation and, xii, 12
— pollen fevers and, ix, 119
— relative percentage in artificial and sunlight, vii, 219
— rickets and, vi, 182; xiii, 114
— rickets treated by, x, 244
— salts and, xiii, 17
— whooping-cough and, xiv, 137
Umbilical adenomata, xv, 282
Umbilical cord, fetal circulation and, ii, 192
— hernia into, treatment of, xv, 256
— ligation of, ii, 124
— pressure on, labor and, i, 150
— weight loss and tying of, ii, 37
Umbilical cysts, xv, 282
Umbilical dressing, ii, 124
Umbilical fistulæ, xv, 282
Umbilical hernia, acquired, iii, 158
— cause of, iii, 157
— clinical features of, xv, 256, 257
— congenital, iii, 156
— general considerations of, iii, 156
— treatment of, xv, 256, 258
— types of, iii, 157
Umbilical infection, convulsions following, v, 129
Umbilical phlebitis, pleural infection from, iii, 94
Umbilical tumors, xv, 282
Umbilical vessels, obliteration of, causes of, ii, 53
Umbilicus, affections of, incidence of, xv, 281
— angioma of, iii, 409
— Buhl's disease and, iii, 4, 5
— congenital malformations of, iii, 399
— delayed healing of, iii, 402
— diphtheria of, iii, 25, 405
— diseases of vessels of, iii, 406
— endocarditis following infection of, iii, 118
— fistula of, iii, 400
— gangrene of, iii, 405
— granuloma of, iii, 408
— hemorrhage from, iii, 401
— — hemorrhagic disease and, ii, 235
— — mortality due to, ii, 4
— infection by way of, iii, 11
— infections of, iii, 404
— injuries to, iii, 402
— leprosy in, iii, 64
— polyp of, iii, 400
— sepsis neonatorum and, iii, 12
— tetanus neonatorum and, iii, 32
— tumors of, iii, 408
— Winckel's disease seldom showing infection of, iii, 1
Uncinarial dermatitis, xvi, 171
Unconscious, psychology of the, iv, 69
Underdevelopment, dwarfism and, x, 135
— infantilism and, x, 139
— overdevelopment and, x, 134, 142
Underfeeding, infancy and, iv, 45
— — etiology of, x, 161
— — symptoms of, x, 162
— — treatment of, x, 163
— intervals and, xii, 138
— result of mother, xii, 187
— signs of, ii, 186
— tuberculosis and, iv, 144
Underweight, food requirements in premature and, xii, 96, 102, 106
— intervals of feeding and, xii, 138
Underweight children, mortality among, xii, 7
— nutritional characteristics of, xii, 5
Undescended testis, cause of, xv, 267
— clinical features of, xv, 268

Undescended testis, treatment of, xv, 269
Universal congenital atrichia, iii, 350
Unsaturation, oxygen, cyanosis and, ii, 204
Ununited fractures, vi, 174
— treatment of, vii, 158
Upper extremities, deformities of, vii, 55
— development of, x, 60, 76
— orthopedic examination of, vi, 25
— poliomyelitis affecting, operative measures for, vi, 233
— tuberculosis of joints of, vi, 95
Upper respiratory infections, malnutrition and, iv, 153
— prevention of, iv, 131
Urachus, abscess of, xix, 18
— cysts of, xv, 283
— fistula of, xv, 282
— — general considerations of, iii, 265
— — Meckel's diverticulum and, iii, 165
Urates, significance of, xx, 18
Urea, administration of, symptoms of, xix, 92
— nephrosis treated by administration of, xix, 91
— significance in blood, xx, 130
Urea coefficient, ii, 103
Urea nitrogen, blood and, ii, 76
— urine and, ii, 102
Urea ratios, kidney function and, xx, 20
Urea test, renal function and, xix, 42
Uremia, acidosis in, xx, 173
— asthenic, symptoms of, xix, 113
— blood chemistry in, xx, 155
— clinical characteristics of, xx, 154
— diffuse glomerulonephritis and, xix, 112, 114
— — treatment of, xix, 124
— eclamptic, symptoms of, xix, 112
— treatment of, xix, 124
Ureters, anomalies of, xix, 8
— duplication of, chronic pyelitis and, xix, 153
— length of, xix, 17
— newborn, anatomy of, iii, 258
Ureters, newborn, anomalies and malformations of, iii, 265
— points of constriction in, xix, 17
— stone in, chronic pyelitis and, xix, 159
— valves in, xix, 17
Urethra, bacteriology at birth, ii, 119
— embryological considerations of, xix, 8
— female, anatomy of, xix, 18
— male, anatomy of, xix, 18
— newborn, anatomy of, iii, 259
— — anomalies and malformations of, iii, 266
— obstruction of, causes of, xix, 215
— — treatment of, xix, 216
— posterior obstruction of, chronic pyelitis and, xix, 158
Urethritis, incidence in male, xix, 219
— treatment in male, i, 61; xix, 220
Uric acid, blood of newborn and, ii, 77
— excretion of, ii, 103
— infarcts of, ii, 103
— significance in blood, xx, 130
— urine and, ii, 102
Uric acid infarcts, xix, 180
Urinary bladder, anatomy of, iii, 258
Urinary lithiasis, clinical features of, xv, 362
— treatment of, xv, 363
Urinary obstruction, diagnosis of, xv, 350
— incidence of, xv, 349
— treatment of, xv, 352
Urinary tract, anomalies and malformations of, iii, 264
— disorders of albuminuria, xix, 59
— — calcariuria, xix, 66
— — chyluria, xix, 67
— — discoloration of the urine, xix, 67
— — enuresis, xix, 47
— — hematoporphyrinuria, xix, 67
— — hematuria, xix, 69
— — hemoglobinuria, xix, 68
— — pollakiuria, xix, 66
— — polyuria, xix, 64
— physiology of, ii, 100
— prematurity modifying, ii, 168

Urinary tract, pyogenic infections of, ascending infection causing, xix, 144
— — bacteriology of, xix, 140
— — chronic form of, xix, 149
— — complications of, xix, 161
— — course of, xix, 161
— — definition of, xix, 138
— — diagnosis of, xix, 163
— — etiology of, xix, 139
— — hematogenous origin of, xix, 143
— — history of, xix, 138
— — incidence of, xix, 139
— — localization of infection in, xix, 139
— — mode of infection in, xix, 143
— — pathology of, xix, 141
— — perinephritis and perinephritic abscess and, xix, 174
— — prognosis of, xix, 169
— — relapses in, xix, 161
— — symptoms of, xix, 146
— — treatment of, xix, 169, 173
Urination, frequency of enuresis and, xix, 51
— — newborn and, ii, 100
— physiological considerations of, xix, 27
— psychic influences upon, xix, 30
— urgency of, enuresis and, xix, 51
Urine, albumin in, xx, 3, 5
— — growth causing, xix, 60
— — incidence of, xix, 60
— — posture causing, xix, 61
— — significance of, xix, 59
— alkapton in, xx, 12
— alterations in color of, xx, 24
— analysis of, i, 18, 21, 160, 162, 166
— — casts in, i, 21, 37, 38
— — chemical, xx, 4
— — colon bacillus infection and, i, 88
— — importance of, xx, 1
— — routine chemical, xx, 4
— bacteria in, etiology of, xix, 205
— — treatment of, xix, 206
— Bence-Jones protein in, xx, 8
— bile pigments in, xx, 12
— blood in, xx, 13
— casts in, xix, 35; xx, 17
— chyle in, xx, 12
Urine, collection of specimen from, female infant, xx, 1
— — male infant, xx, 2
— — methods of, xix, 34
— composition of, influence of purine-free and high purine diets on, xx, 23
— — normal, xx, 23
— concentration tests of, kidney function and, xx, 21
— crystals in, xx, 18
— discoloration of, significance of, xix, 67
— enuresis and changes in, xix, 50
— epithelial cells in, xx, 16
— examination of, xix, 35
— — pyelitis diagnosis and, xix, 164
— englobulin in, xx, 6
— fat in, xx, 12
— formation of, theories on, xix, 21
— hematoporphyrin in, xx, 10
— — hydroa vacciniforme and, xvi, 97
— hemoglobin in, xx, 11
— kidney function tests and, xx, 19
— microscopic examination of, xx, 12
— mucin in, xx, 6
— mucus in, xx, 16
— nephrotic changes in, xix, 86
— newborn, abnormal constituents in, iii, 274
— — acetone content of, ii, 107
— — acidity of, ii, 99
— — albumin in, ii, 107
— — amino-acid nitrogen content of, ii, 105
— — ammonia content of, ii, 105
— — amount of, ii, 37; xx, 4
— — bilirubin content of, ii, 107
— — characteristics of, xx, 3
— — chlorin content of, ii, 106
— — collection of, apparatus for, iii, 271
— — color of, ii, 101
— — constituents of, ii, 102
— — creatinin content of, ii, 105
— — indican content of, ii, 106
— — infarct, ii, 101, 103
— — nitrogen of, ii, 102
— — oxalic content of, ii, 107
— — phenol in, ii, 106
— — phosphorus content of, ii, 106

Urine, newborn, quantity passed, ii, 101
— — reaction of, ii, 101; xx, 4
— — solid elements of, ii, 107
— — specific gravity, ii, 101
— — sugar content of, ii, 107
— — total nitrogen of, ii, 102
— — toxicity of, ii, 107
— — urea nitrogen of, ii, 102
— normal, composition of, xx, 23
— nucleoprotein in, xx, 6
— occult blood in, test for, viii, 343
— organized sediments in, xx, 13
— pentose in, Bial's orcin test for, xx, 9
— phenolsulphonephthalein excretion in, xx, 20
— pregnancy and, i, 34
— preservation of, xx, 1
— pus-cells in, xx, 13
— pyelitis in, i, 34, 35
— scurvy and blood in, xiii, 121
— specific gravity of, age and, xiii, 41
— — diabetes insipidus and, xiii, 86
— sugar in, diabetes mellitus and, xiii, 101, 102
— toxemias of, i, 37
— typhoid fever and, viii, 188
— — De Silvestri's color reaction in, viii, 343
— unorganized sediments in, xx, 18
— urobilin in, xx, 11
Urobilinuria, significance of, xx, 11
Urogenital sinus, development of, xix, 8
— extent of, xix, 8
Urogenital tract, infections of, malnutrition and, iv, 153
Urotropin, poliomyelitis and, vi, 226
— pyelitis of pregnancy and, i, 36
— typhoid fever and, viii, 193
Urticaria, acute bronchitis and, ix, 102
— asthma and, ix, 111
— course of, xvi, 74
— diagnosis of, xvi, 75
— erythema multiforme differentiated from, xvi, 62
— etiology of, xvi, 74
— factitious, xvi, 74
— giant, xvi, 76
Urticaria, lichen planus differentiated from, xvi, 144
— papular, diagnosis of, xvi, 80
— — etiology of, xvi, 79
— — incidence of, xvi, 78
— — pathology of, xvi, 79
— — prognosis of, xvi, 81
— — symptoms of, xvi, 79
— — treatment of, xvi, 80
— pathology of, xvi, 74
— prognosis of, xvi, 76
— scabies differentiated from, xvi, 166
— symptoms of, xvi, 73
— treatment of, xvi, 76
— vaccination and, xiv, 114
Urticaria pigmentosa, diagnosis of, xvi, 31
— etiology of, xvi, 31
— general considerations of, iii, 320
— pathology of, xvi, 31
— symptoms of, xvi, 28
— treatment of, xvi, 31
— xanthoma differentiated from, xvi, 331
Uterus, abortion and, i, 45, 47, 48
— — technic of, i, 29
— abruptio placentæ and, i, 52-56
— anatomy of, xix, 19
— colon bacillus infection and, i, 88
— contractions of, i, 169
— — nursing and, i, 142
— — Wassermann reaction affected by, i, 76
— curettage and, i, 104
— death in, i, 49, 50
— development of, x, 68, 77
— emptying of, i, 42, 47, 56
— heart conditions and, i, 32
— — infections and, i, 92
— — technic of, i, 29
— faulty posture causing displacements of, x, 217
— forcible reposition of, i, 20
— misplacements of, correction of, i, 19, 30
— myomata of, prenatal care and, i, 42
— newborn, anatomy of, iii, 260
— — anomalies and malformations of, iii, 263
— perforation of, abortion and, i, 47
— position of, importance of, i, 18, 19

Uterus, position of, nausea and vomiting due to, i, 25
— puerperal, i, 89, 104
— removal of, lacerations and, i, 97
— retrodisplacement of, i, 19
— — abortion and, i, 45
— ruptures of, shock and, i, 130, 133
— septic treatment of, i, 90, 98, 99
— staphylococcal infection of, i, 87
— streptococcal infection of, i, 89
— tamponage of, i, 48, 59, 60, 110
— tumors of, i, 41
Urea, ectropion of, iii, 356
Uvula, acute edema of, treatment of, ix, 48
— elongated, iii, 134; viii, 38
— — character of cough of, ix, 99
— — treatment of, ix, 47
— syphilis affecting, viii, 18
Uvula bifida, iii, 77

Vacations, hygiene and, iv, 86
Vaccination, complications of, xiv, 113
— pressure method of, xiv, 109
— Public Health regulations for, xiv, 114
— revaccination, xiv, 112
— smallpox, erythema multiforme following, xvi, 61
— — methods of, iv, 139
— spurious, xiv, 112
— technic of, xiv, 107
— time of, xiv, 106
Vaccines, autogenous, chronic infectious arthritis and, vi, 105
— colitis and, viii, 202
— dysentery, viii, 183
— furunculosis and, xvi, 218
— paratyphoid prophylaxis and, viii, 198
— pertussis, diagnostic use of, xiv, 127
— — therapeutic use of, xiv, 137
— qualifications for use of, xiv, 7
— typhoid, viii, 193
— — psoriasis and, xvi, 130
Vaccine therapy, accessory nasal sinus disease and, ix, 37
— acute follicular tonsillitis and, ix, 54
Vaccine therapy, acute rhinitis and, ix, 9
— bronchopneumonia and, ix, 136
— chronic bronchitis and, ix, 108
— enlarged non-tuberculous bronchial glands and, ix, 211
— epidemic sore-throat and, ix, 46
— method of use of, respiratory diseases and, ix, 282
— pollen fevers and, ix, 119
Vaccine virus, character of, xiv, 105
Vaccinia, blood-count in, xi, 47
— course of, xiv, 111
— definition of, xiv, 104
— history of, xiv, 104
— insusceptibility to, xiv, 112
— leukocytosis in, xx, 43
— symptoms of, xiv, 111
— synonyms of, xiv, 104
— technic of vaccination, xiv, 107
— vaccination time, xiv, 106
— vaccine virus and, xiv, 105
Vagina, abortion and, care at, i, 29
— anatomy of, xix, 19
— asepsis and, labor, i, 109
— bacteria in, puerperal sepsis caused by, i, 87, 88, 91, 94, 95
— colon bacillus in, i, 88
— drainage of, labor and, i, 98
— examination of, i, 160
— — infections following, i, 62, 87, 95
— gonococcal infection of, course and complications of, xix, 226, 227
— — diagnosis of, xix, 227
— — incidence of, xix, 225
— — symptoms of, xix, 226
— — treatment of, xix, 227
— — — argyrol, i, 61
— hygiene of, i, 95
— infections of, i, 88, 97
— — local treatment of, i, 98
— lacerations of, i, 89
— — repair of, i, 97
— newborn, anatomy of, iii, 260
— — anomalies and malformations of, iii, 263
— secretion at birth, ii, 110
— sterile at birth, ii, 118
— streptococcus in, i, 87
— — percentage of, i, 95
— tamponage of, i, 97, 110

Vagina, tamponage of, abortion and, i, 48
— — abruptio placentæ and, i, 56
— — placenta prævia and, i, 59
— tumors of, diagnosis of, xix, 224
Vaginal douche, i, 48, 61, 95, 96, 109
— puerperal infection contraindicating, i, 99
Vaginal smear, pregnant cases and, i, 160
Vaginitis, diphtherial, xix, 229
— gonorrheal, xix, 225; xx, 93
— simple, etiology of, xix, 228
— — symptoms of, xix, 229
— — treatment of, xix, 229
Vagotonia, viii, 126
Vagus, lumbar puncture stimulating, v, 93
Vajuolo, synonyms of, xiv, 80
Valgus, congenital, treatment of, vi, 286
Valvular endocarditis, pathology of, xviii, 27
Van Arsdale splint, application of, xv, 77
Van den Bergh's test for bilirubinemia, 40, xx
Vaquez' disease, discovery of, xi, 5
Varicella, blood-count in, xi, 47
— bronchopneumonia secondary to, ix, 122, 130
— erythema scarlatiniforme and, xvi, 59
— impetigo contagiosa differentiated from, xvi, 207
— papular urticaria differentiated from, xvi, 80
— synonyms of, xiv, 69
Varicella gangrenosa, xiv, 75
Varicellen, synonyms of, xiv, 69
Varicose veins, clothes causing, i, 162
— congenital, iii, 112
— pregnancy and, i, 168
— treatment of, illus., i, 167
Variola, blood-count in, xi, 47
— erythema multiforme resembling, xvi, 62
— infection of fetus with, iii, 10
— leukocytosis in, xx, 44
— synonyms of, xiv, 80
Variola notha, synonyms of, xiv, 69
Variola spuria, synonyms of, xiv, 69
Varus, treatment of, vi, 286
Vas deferens, development of, xix, 5
Vascular disease, newborn, iii, 118
Vascular lesions, bulbo-medullary hemorrhage and, newborn, i, 120
Vascular nevi, types of, xvi, 1
Vascular supply, interference with, fetal abnormalities caused by, i, 67
Vaselin oil, Winckel's disease and, iii, 2
Vasomotor rhinitis, ix, 117
Vegetables, bottle feeding supplemented by, xii, 134
— breast feeding and, iv, 49
— caloric value of, x, 192
— chemical composition of, x, 287, 288
— diet of pregnancy and, i, 23, 165
— normal child and, x, 123
— vitamin content of, x, 283
Vegetable parasites, skin diseases due to, iii, 349
Vegetations, adenoid, digestive system affected by, viii, 50
Veins, internal jugular, intracranial pressure and, v, 122
— newborn, anomalies of, iii, 112
— rheumatic infection of, pathology of, xviii, 39, 83
— varicose, clothes causing i, 162
— — pregnancy and, i, 168
— — treatment of, illus., i, 167
Venepuncture, technic of, xx, 128
Venereal disease, education and, iv, 100
Venereal wart, xvi, 319
Venesection, convulsions at labor and, i, 38
Ventilation, art of infant feeding and, xii, 145
Ventral hernia, general considerations of, iii, 159; xv, 265
— growth and, xv, 2
Ventricular endocarditis, pathology of, xviii, 24
Ventricular fibrillation, electrocardiographic determination of, xviii, 180

Ventricular hemorrhage, peculiarities of, ii, 172
Ventricular predominance, electrocardiographic determination of, xviii, 168
Ventricular puncture, v, 87
— intracranial hemorrhage and, v, 44
— technic of, xx, 96
Vernix caseosa, composition of, ii, 109
— description of, ii, 10
— ichthyosis sebacea and, xvi, 16
— presence in meconium, ii, 92
— removal of, ii, 125
— weight loss and, ii, 37
Verruca acuminata, gonorrhea and, i, 61
Verruca plana juvenilis, xvi, 319
Verruca vulgaris, xvi, 318
Verrucæ, course of, xvi, 320
— etiology of, xvi, 320
— pathology of, xvi, 320
— symptoms of, xvi, 318
— treatment of, xvi, 321
Verrucous endocarditis, pathology of, xviii, 186
Version delivery, abortion and, i, 43
— abruptio placentæ and, i, 56
— advantages of, v, 24
— Braxton-Hicks, placenta prævia and, i, 60
— cardiac cases and, i, 33
— collapse in, i, 131
— conservatism and, i, 19
— decompensation and, i, 32
— internal podalic, placenta prævia and, i, 60
— spinal injuries and, i, 120, 121
Vertebræ, acute infection of, vi, 62
— cervical, fractures of, breech delivery and, i, 8, 121
— congenital anomalies of, vi, 278
— spondylolisthesis of, vi, 270
— tuberculosis of, complications of, vii, 123
— — diagnosis of, vii, 122
— — dwarfism and, xiii, 152
— — etiology of, vii, 119
— — history of, vii, 118
— — pathology of, vii, 119
— — prognosis of, vii, 123
— — symptoms of, vii, 120
Vertebræ, tuberculosis of, treatment of, vii, 123
Vertebral compressibility, v, 22
Vertex delivery, birth injuries in, i, 117
— clavicular fracture in, i, 121
Vertex presentation, brachial paralysis and, v, 26
Vesical calculi, xix, 209
Vespidæ, iii, 348
Vestibular nystagmus, ii, 115
Vicarious menstruation, epistaxis and, ix, 19
Villemin, tuberculosis studied by, ix, 216
Vincent's angina, acute follicular tonsillitis differentiated from, ix, 53
— diagnosis of, ix, 47
— diphtheria complicated by, xiv, 167
— diphtheria differentiated from, xiv, 168
— etiology of, viii, 41; ix, 46
— hereditary syphilis differentiated from, xvii, 249
— pathogenic organisms of, xx, 92
— symptoms of, viii, 41
— treatment of, viii, 41; ix, 47; xv, 180
— ulcerative stomatitis and, viii, 27
Virchow, syphilis described by, xvii, 8
Viruelas, synonyms of, xiv, 80
Virulence, factors determining, xiv, 2
— scarlet fever, xiv, 12
Virus, poliomyelitis, xiv, 232
— rabies, route toward brain of, xiv, 328
Viscera, development of, x, 65, 74, 77
— gumma of, pathology of, xvii, 37
— syphilis of, incidence of, xvii, 168
— — infants and, i, 73-75
— Wassermann reaction in, i, 78
Visceral abscesses, thrombophlebitis causing, i, 94
Visceral ectopia, iii, 156
Visceroptosis, albuminuria caused by, xix, 61
— gastro-intestinal disturbances due to, viii, 270
— manifestations of, viii, 271

Visceroptosis, orthopedic considerations of, vi, 272
— poliomyelitis causing, vi, 225
— treatment of, viii, 272
Viscosity blood, newborn, ii, 65
Vision, brain tumors causing disturbances of, v, 118
— care of, at birth, i, 62, 137, 169
— congenital syphilis and, i, 76
— defective, malnutrition and, iv, 156
— disturbance of, pregnancy and, i, 168
— newborn deficient in, ii, 7
— prenatal care and, i, 16
— protection of, gonococcal infection and, i, 62, 94
— pubescence and increase in defects of, iv, 121
— testing of, iv, 157
— toxemias and, i, 37
Vital blood staining, xx, 42
Vital capacity of lungs, enlarged non-tuberculous bronchial glands and reduction of, ix, 209
— rheumatic fever diminishing, xviii, 55
Vital staining, purpose and technic of, xi, 29
Vitamin-A, birth weight and, ii, 14
— foods containing, x, 28
— prophylactic use of, ix, 9
— source of, x, 22
— value of, x, 22
— xerophthalmia (keratomalacia) and, xiii, 130
Vitamin B, beriberi and, x, 22, 264; xiii, 134
— foods containing, x, 29
— source of, x, 23
Vitamin C, foods containing, x, 29
— infantile scurvy due to deficiency in, xvi, 71
— scurvy and, xiii, 119, 126; x, 23, 219, 227
— source of, x, 23
Vitamin D, foods containing, x, 29
— osteomalacia and, xiii, 167
— rickets and, x, 24; xiii, 114, 117
— rickets prevented by supply of, iv, 122
Vitamin E, source of, x, 24
Vitamin X, source of, x, 24
Vitamins, additions to bottle feeding and, xii, 130
— antineuritic, x, 22
— anti-ophthalmic, x, 22
— antirachitic, x, 24
— antiscorbutic, x, 23
— antisterility, x, 24
— calcium depositing, x, 24
— classification of, x, 21
— derivation of term, x, 21
— eggs and, xii, 133
— evaporated milk and, xii, 27
— fat and, xii, 85; xiii, 16
— foods and, x, 283-285
— food value of, x, 20
— fruits and, xii, 131
— functions of, x, 22
— growth and, iv, 14
— harelip and cleft-palate and, iii, 131
— infant feeding and, iv, 54
— milk and, x, 27; xii, 10, 12, 17
— — human, xii, 159, 163
— premature infant and, xii, 105
— synonyms for, x, 21
— teeth and, viii, 64
— vegetables and, xii, 134
Vitiligo, diagnosis of, xvi, 293
— etiology of, xvi, 219
— pathology of, xvi, 290
— prognosis of, xvi, 294
— symptoms of, xvi, 289
— treatment of, xvi, 294
Vocal chords, physiology of, ix, 75
Volkmann's contracture, general considerations of, vii, 239
— management of, vii, 159
Volkmann's paralysis, diagnosis of, vi, 212
— etiology of, vi, 211
— management of, vii, 159
— pathology of, vi, 212
— prognosis of, vi, 213
— symptoms of, vi, 212
— treatment of, vi, 213
Volume, newborn lung, ii, 53
Volume index of blood, xx, 32, 33
Voluntary control, selection and initiation of, v, 3
Volvulus, congenital, treatment of, viii, 237; xv, 280

Volvulus, Meckel's diverticulum and, viii, 246
— newborn, iii, 196
Vomiting, acute appendicitis and, xv, 306
— aspiration of products of, cyanosis caused by, ii, 205
— atresia of small intestine causing, iii, 148
— blood-sugar and, xx, 162
— brain tumors causing, v, 18, 118
— breast feeding and, xii, 175
— — intervals of, ii, 148
— congenital atresia of esophagus and, iii, 137
— congenital pyloric stenosis and, iii, 141
— constipation causing, xii, 114
— cyclic, description of, viii, 134
— — diagnosis of, viii, 136
— — etiology of, viii, 134
— — prognosis of, viii, 136
— — symptoms of, viii, 135
— — treatment of, viii, 137
— elongated uvula causing, iii, 135
— fat causing, ii, 184
— fat indigestion and, xii, 78, 115
— fear causing attacks of, iv, 71
— gastric indigestion and, xii, 111
— general considerations of, iii, 171
— habitual, thumb sucking and, xii, 114
— hemorrhage and, viii, 108
— hypertrophic pyloric stenosis and, viii, 115, 120
— infant and, viii, 92
— — causes inherent in food, viii, 93
— — eruption of teeth and, viii, 94
— — feeding of, i, 145
— — frozen milk and, viii, 95
— — intestinal influenza and, viii, 95
— — mechanical vomiting, viii, 92
— — simple regurgitation, viii, 92
— — toxic vomiting, viii, 95
— — treatment of, viii, 96
— — vomiting of central origin, viii, 95
— insufficient food causing, xii, 94, 100, 114
— irregular frequent feeding causing, xii, 90
Vomiting, ketosis-acidosis associated with, xiii, 28
— ketosis caused by, xx, 170
— mechanical causes of, xii, 114
— meningitis causing, v, 85
— overfeeding causing, ii, 186
— paratyphoid in newborn and, iii, 30
— peculiarity of newborn, ii, 172
— pernicious, labor and, i, 5, 130
— — syphilitics and, i, 80
— pregnancy and, i, 25, 26, 168
— — cystoma of, acute, i, 42
— — toxemias of, i, 37
— repeated, iii, 173
— sepsis neonatorum causing, iii, 15
— toxic, treatment of, xii, 116
— weight loss due to, ii, 38
— Winckel's disease causing, iii, 3
Von Jaksch's anemia, blood-picture of, xi, 98; xx, 59
— course of, xi, 112
— diagnosis of, xi, 111
— leukemia and, xi, 130
— physical signs of, xi, 110
— symptoms of, xi, 109
— treatment of, xi, 112; xv, 335
Von Pirquet's skin test, diagnostic value of, ix, 231
— enlarged tracheobronchial glands and, ix, 209
— joint tuberculosis and, vi, 71
— method of procedure in, ix, 287
— pleurisy with effusion and, ix, 198
— pneumonia negating, ix, 231
— technic and interpretation of, xiv, 336, 360
Voorhees bag, induction, labor and, i, 108
— placenta prævia and, i, 60
Vulva, anatomy of, xix, 20
— colon bacillus infection and, i, 88
— diphtheria of, xiv, 165
— erysipelas, incidence of, xix, 229
— — treatment of, xix, 230
— gonorrheal conditions of, i, 61
— — argyrol treatment of, i, 62
— newborn, anomalies and malformations of, iii, 263
— — bacteriology of, ii, 119
— preparation of, labor and, i, 95
— streptococcus infection of, i, 87, 95

Vulva, varicosities of, postural treatment for, i, 168
Vulvovaginal glands, abscesses of, i, 62
— gonorrhea and, i, 61
Vulvovaginitis, gonorrheal, malnutrition and, x, 188
— newborn, iii, 271

Waldeyer's ring, anatomy and physiology of, ix, 39, 49
Walking, pregnancy and, i, 24, 40
Warts, course of, xvi, 320
— etiology of, xvi, 320
— pathology of, xvi, 320
— symptoms of, xvi, 318
— treatment of, xvi, 321
Wasps, iii, 348
Wassermann reaction, acquired syphilis and, iii, 38; xvii, 240
— blood, xvii, 44
— bone and joint syphilis and, vi, 71, 101, 139
— congenital syphilis and, iii, 50
— criteria of cure in terms of, xvii, 256
— early congenital syphilis of bones and joints and, vii, 146
— epilepsy and hydrocephalus, v, 82
— infants and, i, 81
— — prenatal treatment and, i, 82
— — syphilitic, i, 66, 83
— interpretation of, xvii, 46
— mother's blood in congenital syphilis, iii, 50
— neurosyphilis and, xvii, 186
— nursing of syphilitic infants and, i, 66
— parents of syphilitic children and, xvii, 66
— pregnant women and, i, 76-78, 160
— — incidence charts, i, 65, 69
— reading the degrees of, xvii, 45
— relative value of Kahn test and, xx, 69
— routine in prenatal care, ii, 122
— sperm studies in relation to, i, 67
— spinal fluid, xvii, 51
— — neurosyphilis and, xvii, 179
Wasserpocken, synonyms of, xiv, 69
Wasserscheu, synonyms of, xiv, 324
Water, acidosis and administration of, x, 274
— administration of, methods of, viii, 339
— amount of loss of, ii, 38
— bodily requirements of, x, 19; xx, 132
— bottle feeding supplemented by, xii, 130
— carbohydrates and retention of, x, 16, 20
— colic and, iii, 178
— content in blood, ii, 75
— course through body, xx, 33
— dehydration fever and, xiii, 40
— diet of pregnancy and, i, 164, 166
— early decrease in size due to loss of, ii, 32
— excretion of, x, 20
— metabolism of, xx, 132
— milk and, x, 27
— newborn infants and, xii, 171, 176
— results of excessive loss of, xx, 133
— retention of, inanition and, x, 214
— — obesity and, x, 153
— testing kidney function with, xix, 37
— transitory fever caused by impoverishment of supply of, ii, 208
— use before institution of breast feeding, ii, 147
— weight loss arrested by administration of, ii, 37
Water inanition, x, 159
Water-soluble vitamin B, beriberi and, x, 264
Water-soluble vitamin C, scurvy and, x, 219, 227
Weak foot, deformity in, vi, 257
— diagnosis of, vi, 258
— examination of, vi, 257
— symptoms of, vi, 257
— treatment of, vi, 258
Weaning, breast feeding and, xii, 179
— complemental feeding and, iv, 50
— gastric indigestion and, xii, 110
— supplemental feeding and, iv, 50
Webbed fingers, mongolism and, v, 189

Wechsberg, complement deviation described by, xvii, 15
Wechselfiber, synonyms of, xiv, 209
Wegner's line, x-ray of, test for congenital syphilis and, i, 78
Weight, accessory nasal sinus disease and, ix, 29
— age and height tables, iv, 17
— anhydremia causing loss of, x, 159
— avoirdupois and metric, conversion table of, x, 292
— birth, average, x, 79
— — first year increase over, iv, 14
— — gestation and, iv, 16
— — mortality in relation to, ii, 6
— — race influencing, iv, 17
— — recovery of, ii, 40
— — sex influence upon, iv, 17
— body, carbohydrates promoting, x, 16
— circumcision affecting, ii, 135
— fetal, x, 44
— — age and, ii, 161
— — determination of, ii, 132
— — diet of mother and, ii, 122
— food and, ii, 43
— food requirements, xii, 65
— — premature and, xii, 96
— height and age table during preschool age, iv, 21
— height by age and, iv, 18
— importance of height comparisons with, iv, 29
— increment at different ages, iv, 21
— infant, breast milk and, i, 145
— — chart for record of, iv, 192
— initial loss of, x, 92
— — artificial food and, ii, 149
— — inanition and, x, 209
— — prematurity and, ii, 169
— loss of, acute fasting or inanition and, xiii, 24
— — amount endured before death, x, 210
— — cyclic vomiting causing, viii, 136
— — hypertrophic pyloric stenosis causing, viii, 117, 124
— — inanition and, x, 206
— — starvation in adult and, x, 207
— — starvation in young and, x, 208
Weight, malnutrition in older children and, x, 172
— metabolism and, ii, 97, 149; xiii, 10
— metric and avoirdupois, conversion table of, x, 292
— normal, x, 99
— over- and under-food requirements in premature and, xii, 96, 102, 106, 107
— pregnancy and, diet of, i, 24
— rate of increase from birth to adult, x, 79
— record kept of, ii, 133
— relation to intake and output, ii, 38
— rheumatic infections and, xviii, 55, 77
— seasonal variation in, ii, 14
— social influence on, ii, 17
— successful nursing and, xii, 184
— sweat and loss of, ii, 109
Weight—body surface, metabolism and, xiii, 11
Weight-gain, breast feeding and, ii, 43
— metabolism and, ii, 42
— normal, infancy, iv, 24
Weight—height, age and, xiii, 6
— average (boy) tables of, x, 111, 112
— average (girl) tables of, x, 113, 114
— birth to three years, x, 80
— boys (6 years to 18 years), x, 82
— girls (6 years to 18 years), x, 82
— growth measured by, xiii, 19
— total heat output and, xiii, 6, 8
Weight-loss, initial, birth weight and, ii, 37
— — causes of, ii, 37, 39
— — dehydration fever and, ii, 210
— — disease causing, ii, 39
— — excretion of waste materials causing, ii, 156
— — jaundice and, ii, 37
— — parity and, ii, 36
— — physiologic, ii, 34
— — prematurity and, ii, 169
— — relation to breast feeding, ii, 36
— — sweat and, ii, 109
— — umbilical cord tying in relation to, ii, 37
— — vomiting causing, ii, 38

Weight-loss, initial, water administration diminishing, ii, 37
— — wet-nursing and, ii, 37
Weisses Blut, xi, 4
Welfare, child, prenatal care and, i, 6, 11, 12, 15, 150-175
Wen, xvi, 282
Werdnig-Hoffmann, infantile progressive muscular atrophy of, iii, 250; v, 69; vii, 252
Werlhoff's disease, blood changes in, xx, 63
Wet-nurses, i, 157
Wet-nursing, children of tuberculous mothers, and, i, 27
— weight-loss diminished by, ii, 37
Whey, feeding and, newborn, i, 142
— milk sugar from, xii, 40
— mixtures of cream and, xii, 26
— preparation of, xii, 26
Whining, newborn and, i, 137
Whip-worm, intestinal infestation with, viii, 304
Whiskey, eggnog and, septic patients and, i, 98
— lobar pneumonia and, ix, 166
White blood-cells, age and possible variation in number of, xi, 38
— average number of, xi, 39
— classification of, xi, 16
— counting of, xi, 25
— formation and origin of, xi, 18
— functions of, xi, 6
— infancy and childhood and, xv, 50
— miscellaneous conditions affecting number of, xx, 42
— morphology of, xi, 16
— newborn, characteristics of, ii, 68, 71
— number of, xx, 34
— number during adolescence, xi, 44
— number during childhood, xi, 43
— number during infancy, xi, 41
— original description of, xi, 2
— significance of abnormalities in, xi, 20
White nail, xvi, 269
White precipitate ointment, xvi, 349
White swelling, diagnosis of, vii, 129
— pathology of, vii, 128
— prognosis of, vii, 130
White swelling, symptoms of, vii, 129
— treatment of, vii, 130
Whitfield's ointment, xvi, 349
Whitlow, xvi, 270
Whitman's reduction of epiphyseal separation of femur, vi, 168
Whooping-cough, acute bronchitis and, ix, 101
— acute infectious arthritis and, vi, 50
— adenoids and, ix, 68
— atypical forms of, xiv, 123
— blood-count in, xi, 47
— bronchopneumonia following, ix, 122, 130
— cerebral palsies caused by, v, 142
— character of cough of, ix, 101
— chronic bronchitis following, ix, 107
— complications of, xiv, 123
— definition of, xiv, 117
— diagnosis of, xiv, 126
— epistaxis and, ix, 18
— etiology of, xiv, 118
— foreign bodies in respiratory tract and, ix, 191
— history of, xiv, 117
— hydrocephalus following, v, 150
— incubation of, xiv, 120
— infant mortality and, iv, 111
— internal medical treatment of, xiv, 135
— leukocytosis in, xx, 43
— nervous sequelæ of, v, 80
— newborn and, iii, 28
— pathology of, xiv, 120
— predisposition to, xiv, 119
— prognosis of, xiv, 129
— prophylaxis of, xiv, 132
— Public Health regulations for, xiv, 139
— pulmonary tuberculosis predisposition following, xiv, 351
— rheumatic infections and, xviii, 78
— rickets and, vii, 193
— specific vaccine treatment of, xiv, 137
— sputum in, characteristic appearance of, xx, 84
— stages of, xiv, 121
— symptoms of, xiv, 120

Whooping-cough, synonyms of, xiv, 117
— treatment of, iii, 29; xiv, 133
Widal test, significance of, viii, 342
— typhoid fever and, viii, 191; xiv, 89
Willems' active motion, acute infectious arthritis and, vi, 55
Wilms' tumor, diagnosis of, xix, 185
— incidence of, xix, 183
— symptoms of, xix, 184
— treatment of, xix, 187
Winckel's disease, bacteria associated with, iii, 2
— blood changes in, xx, 52
— Buhl's disease and, iii, 4
— cause of, iii, 1
— congenital cyanosis and, ii, 205
— diagnosis of, iii, 3
— epidemic character of, iii, 3
— forms of, iii, 3
— hemorrhage and, iii, 185
— history of, iii, 1
— pathology of, iii, 2
— prognosis of, iii, 3
— symptoms of, iii, 2
— treatment of, iii, 4
Windblätten, synonyms of, xiv, 69
Winter hemoglubinuria, late inherited syphilis and, xvii, 169
Witches' milk, iii, 398
Witch-hazel, nipples and, care of, i, 143
Wolfe-Krause skin grafts, scar contractures and, vi, 205
Wolffian ducts, embryology of, xix, 1
Wolfing of food, xii, 139, 154
Woman's milk, chemical composition of, xii, 10
— percentage composition by periods, xii, 161
Womb, contraction of, fear and, i, 169
— nursing and, i, 142
— Wassermann reaction affected by, i, 76
Women, incidence of syphilis among, xvii, 88
Wonder, preventive pediatrics and, iv, 70
Wool, use in infants' clothing, ii, 128
Work, heavy, postpartum uterus and, i, 161
Worms, benign jaundice from, viii, 328
— cutaneous infestation by, xvi, 170
— intestinal infestation with, viii, 296-309
— skin diseases caused by, general considerations of, xvi, 151
Worry, breast feeding and, i, 140, 144
— pregnancy and, i, 24
Wounds, dermatitis caused by, xvi, 33
— labor, treatment of, i, 89, 97, 98
— lacerated, scar contractures following, vi, 201
— soft parts, surgery and, xv, 8
Wrisberg, cuneiform cartilages of, ix, 75
Wrist, acute infectious arthritis of, vi, 67
— fixation of, vi, 44
— nerve injury and trauma of, vi, 252
— poliomyelitis affecting, vi, 225
— — operative measures for, vi, 234
— scar contractures of, vi, 207
— tuberculosis of, vii, 132
— — management of, vi, 96
— Volkmann's contracture of, vi, 212
Wry-neck, vii, 237
— diagnosis of, vi, 293
— orthopedic management, vi, 292
— treatment of, vi, 293

Xanthochromia, ii, 110
Xanthoma, diagnosis of, xvi, 331
— etiology of, xvi, 330
— joints and, vi, 126
— prognosis of, xvi, 331
— symptoms of, xvi, 329
— treatment of, xvi, 331
Xeroderma ichthyosis, iii, 336
Xeroderma pigmentosum, diagnosis of, xvi, 21
— etiology of, xvi, 21
— pathology of, xvi, 21
— prognosis of, xvi, 22
— symptoms of, xvi, 13, 19
— telangiectasia in, xvi, 295
— treatment of, xvi, 22
Xerophthalmia, incidence of, xiii, 129

Xerophthalmia, symptoms of, xiii, 129
— treatment of, xiii, 130
Xerophthalmiakeratomalacia, vitamin A and, x, 22
X-ray, accessory nasal sinus disease and, ix, 31
— acrocephaly and, v, 54
— acute infectious arthritis and, vi, 52
— acute infectious osteomyelitis and, vi, 130
— acute infectious spondylitis and, vi, 64
— adenoids treated by, ix, 74
— alopecia caused by, xvi, 257
— aortic insufficiency and, xviii, 158
— atrophy of bone shown by, vi, 181
— brain tumors diagnosed by, v, 118
— bronchial gland tuberculosis and, xiv, 342
— chronic infectious arthritis and, vi, 104
— chronic osteomyelitis and, vii, 72
— chronic pneumonia and, ix, 171
— clavicular fractures and, vi, 165
— congenital dislocation of hip and, vi, 290
— congenital syphilis and, iii, 46
— convulsions and examination with, v, 137
— coxa plana and, vi, 110
— coxa vara and, vi, 111
— cyanosis and, ii, 206
— eczema and, xvi, 122
— effect on kidney of, xix, 26
— empyema diagnosis and, ix, 202
— enlarged non-tuberculous bronchial glands and, ix, 208, 210
— ethmoid sinus and, ix, 25
— examination of heart by, xviii, 147
— exophthalmic goiter and, xiii, 50
— favus and, xvi, 193
— fetal chondrodystrophy, studies by, vii, 18
— fetal maldevelopment following use of, v, 141
— flat-foot and, vi, 258
— foot and ankle and, vi, 12
— foreign bodies in respiratory tract and, ix, 189
— fragilitas ossium and, vii, 43
— gangrene of lung and, ix, 160
X-ray, Garré's sclerosing osteomyelitis and, vi, 141
— gastro-intestinal diagnosis and, viii, 335
— gonorrhea and, pregnancy and, i, 61
— heliotherapy results in joint tuberculosis shown by, vi, 74
— hip examination by, vi, 18
— hydrocephalus and, v, 57, 115
— hypertrophic rhinitis and, ix, 13
— joint tuberculosis and, vi, 70
— knee and, vi, 14
— Legg's disease and, vi, 110
— lichen planus and, xvi, 144
— lung abscess and, ix, 175
— maxillary sinus and, ix, 23
— megacolon and, iii, 154
— mitral insufficiency and, xviii, 158
— multiple cartilaginous exostoses and, vii, 25
— normal foot, vi, 2
— obstetrical paralysis and, vi; 245
— opaque oil and, v, 122
— orthopedic examination by, vi, 9
— osteitis fibrosa cystica and, vi, 143
— osteochondritis deformans juvenilis and, vii, 76
— osteogenesis imperfecta and, vii, 43
— osteoporosis and, vi, 181
— periosteal sarcoma demonstrated by, vi, 198
— Perthes' disease and, vi, 110
— pleurisy with effusion and, ix, 197
— Pott's disease and, vi, 90
— psoas abscess and hip-joint tuberculosis differentiated by, vi, 82
— psoriasis and, xvi, 132
— rickets and, vi, 182; x, 240; xiii, 115
— ringworm of scalp and, xvi, 184
— sacro-iliac injuries and, vi, 120
— scoliosis demonstrated by, vi, 265
— scurvy and, vii, 210; xiii, 123
— sphenoid sinus and, ix, 25
— spinal tuberculosis and, vi, 90
— Still's disease and, vi, 106
— surgical examination and, xv, 6
— syphilis of bones examined by, vii, 145
— syphilis of joints and, vi, 100; vii, 145

X-ray, syphilitic osteomyelitis and, vi, 138
— thymic enlargement and, iii, 377
— — diagnosed by, xiii, 89
— thymic stridor relieved by, iii, 75
— tonsils treated by, ix, 62
— treatment of heart disease by, xviii, 216
— tuberculosis and, xiv, 361
— — diagnosis of, ix, 232
— — nervous system, v, 84
— Wegner's line, test for congenital syphilis and, i, 78
— whooping-cough and, xiv, 136

Yeast, treatment of intestinal putrefaction with, xx, 126
Yolk, egg, bottle feeding supplemented by, xii, 133
Young children, peritonitis in, clinical features of, xv, 299
— — etiology of, xv, 299
— — treatment of, xv, 301
— tuberculosis in, adrenal, xiv, 355
— — bone and joint, xiv, 356
— — bronchial gland, xvi, 340
— — central nervous system and, xiv, 345
— — cervical gland, xiv, 342
— — diagnosis of, xiv, 340
— — ear, xiv, 349
— — etiology, xiv, 337
— — eyes and, xiv, 348
— — gastro-intestinal system, xiv, 352
Young children, tuberculosis in, introduction, xiv, 332
— — kidney, xiv, 355
— — laboratory methods, xiv, 359
— — liver, xiv, 354
— — lupus vulgaris, xiv, 344
— — miliary, xiv, 355
— — modes of invasion of, xiv, 339
— — primary mesenteric node, xiv, 343
— — psychic disturbances due to, xiv, 355
— — Public Health regulations, xiv, 372
— — pulmonary, xiv, 350
— — respiratory system, xiv, 350
— — roentgenology, xiv, 361
— — serology, xiv, 369
— — spleen, xiv, 355
— — symptomatology of, xiv, 340
— — treatment, xiv, 362

Ziegenpeter, synonyms of, xiv, 141
Zinc oxid ointment, formula of, xvi, 347
Zinc stearate, aspiration of, xv, 244
— — pneumonia from, ix, 177
— use of, ii, 127
Zona, xvi, 87
Zoolak, preparation of, xii, 37
Zoster, xvi, 87
Zoster pectoralis, xvi, 90
"Z" plastic operation, acute infectious arthritis and, vi, 58

SUPPLEMENT

THE NEWBORN — PHYSIOLOGY AND CARE

SUPPLEMENTARY CONTRIBUTION

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INTRODUCTION

There has been an increasing interest manifest in the study of the newly born infant in the last few years, especially with regard to the clinical aspect of this age period. Anatomic and physiologic investigations have failed to keep pace with clinical and pathologic studies so that at present there is great need for research into these illy studied phases of the subject. At best, consideration of the neonatal period has been desultory and it is marked by a decided lack of knowledge, especially in respect to the elementary sciences, due no doubt to the failure upon the part of investigators to make protracted and intensive studies such as have been made upon the adult. In other words, many have taken an occasional fling at it but no one has given it his undivided attention.

Effects of Radiotherapy on Fetus.—The advancement of radiotherapy in gynecology has furnished a problem of extreme interest in relation to its effects upon the embryo. Numerous reports are at hand which seem to indicate that congenital abnormalities may result through modification of the germ cells by irradiation (Schmitt). The functional activity of the unfertilized ova or spermatozoa may be destroyed or so modified by radiotherapy that the offspring may be defective. Early in pregnancy a marked arrest in development may occur, while later in pregnancy irradiation may produce developmental defects and loss of fertility in the offspring. Thus, cases of microcephaly, anencephaly and multiple deformities of the extremities have been reported as probably resulting from the use of x-ray and radium treatments during pregnancy. The work of Baggs is interesting in this respect. By means of irradiation, strains of laboratory animals were produced which manifested a strong tendency to the development of definite congenital defects such as club-foot, congenital amputation, hypodactylism and syndactylism—anatomic abnormalities which are associated with a definite localized arrest in embryonic development. At the present time there is little or no evidence at hand that the fetus will be affected *in utero* when the usual diagnostic doses are used, but there is grave danger when therapeutic doses of Roentgen ray or radium are given during pregnancy, depending upon the period of gestation. In the early months exposure usually results in abortion (Toombs). In the later months deformities, especially of the central nervous system, commonly result (Goldstein). The younger the fetal tissues are when the dose is given, however, the more pronounced the injuries. The data so far collected should serve as a warning against the use of these agents in gynecological conditions, except malignant disease when it is not known whether the patient is pregnant or not.

Mortality and Morbidity.—The newborn period still has the highest mortality rate of any age period. The great majority of these deaths are due to prematurity, congenital debility and birth injuries, with hemorrhage, infections and congenital anomalies coming last. Toxemias of pregnancy play a prominent part in the production of prematurity and congenital debility, and will continue to do so until better methods of antenatal care are adopted by the obstetrician and general practitioner. The importance of antenatal infection as a factor in fetal morbidity and mortality has been emphasized recently. Undoubtedly certain of the infectious conditions of the mother, such as pneumonia, tonsillitis, and nasopharyngitis play a not insignificant rôle in the development of some of the infectious diseases of the newborn. Birth injuries are far too frequent as a result of meddlesome obstetrics and also improperly executed manipulative procedures. High and mid forceps applications have been shown to be associated with much more risk for the child, such as serious mental defect from brain injury, than is the case with those delivered spontaneously or by low forceps and, unfortunately, the indiscriminate use of pituitrin still plays too large a part in the production of birth injuries. The value of pediatric assistance in obstetric clinics, a practice in vogue in many American institutions, is well emphasized by Lyskawinski of Warsaw who reports a decrease in the mortality rate from 4 per cent in 1924 to 1.57 per cent in 1927 by placing the newborn service in the hands of the pediatrician. Such practice is commendable and essential in all obstetric departments, no matter how small the hospital if the mortality rate at this period is to be reduced. We strongly urge the adoption of this program in every institution. It is practical, would save the obstetrician or general practitioner the added burden of caring for the infant, a task usually not relished, and would save the nursery attendants much valuable time because of the adoption of a standard routine of management. All infants would be carefully watched and provided for, a thing which does not happen at present with the usual indifferent or irregular care provided by the many physicians of one hospital staff.

Predisposition to Disease.—Recently considerable attention has been paid to the functional predisposition to disease. There is no doubt that in the newborn there exists the same predisposition to certain types of ailments as in the older child and adult, but owing to the rapid growth and development at this age the recognition of individual or group peculiarities is extremely difficult. Wunderlick classified predisposition into two types: (1) the type which easily throws off all infection—the strong constitution; (2) the type that over-reacts to all irritation—the irritable constitution. The interrelationship between the mother and offspring during pregnancy probably forms a basis for the development of some of these types of predisposition. The amount of the mother's nourishment has little effect upon the fetus, but a deficiency of certain minerals, such as iodin, calcium, and iron, or of essential amino-acids or vitamins will have a marked effect on the infant's skeleton and blood. Illness during pregnancy likewise plays a great part in the predisposition of the infant to disease. All of which further emphasizes the great importance attached to the subject of prenatal care. Naturally the type of the infant cannot be changed by antenatal care, but it can be modified greatly. If inheritance is the tendency of an individual to react to a certain environment in a certain way then surely modification of intra-uterine environment, which is necessarily modification of the parturient's method of living, by improvement of health, will result in inhibiting or changing the offspring's reaction to its own betterment.

ANATOMY AND GENERAL PHYSIOLOGY

Anatomy.—Attempts to classify infants according to their body build has resulted in the use of a classification similar to that in adults (Bakwin and Bakwin). Stockard's classification is the one which at the present time seems to give the best results. The *linear type* is distinguished by a long head, high narrow nasal bridge, more or less sharp and prominent nose, narrow palate, small lower jaw, long thin neck, small chest circumference, narrow shoulders and hips, and long tapering fingers with long nails. This type of child tends to be underweight, and suffers from malnutrition. The *lateral type* of infant has a round head, short face with a large lower jaw, short large neck, large chest, broad shoulders and hips, and short stubby fingers with short nails. These infants tend to put on weight easily and develop eczema. Tetanic infants form an intermediate group which approach more closely the lateral type of body build.

There is a congenital anomaly of the blood-vessels which frequently manifests itself as a transitory violaceous mottling on exposure to cold. This has been so commonly noted that little attention has been paid it, but one is so frequently asked about it by anxious mothers that a few remarks regarding the condition should be made. The terms cutis marmorata and livedo are given this condition. It may show itself as a permanent mottling of variable extent, or it may be a transitory condition revealed only upon impediment of the circulation.

A recent study of the finger nails and toe nails has revealed that the finger nails grow at a uniform rate of about 2.1 centimeters during the first year, and the toe nails about 1.6 centimeter during the first year. The rate of growth of the nails of the fifth fingers and toes is considerably less.

Chemistry.—The brain of the fetus and the newborn infant does not contain any fat or lipoid substance in any stage of the development. The only fat found is in the perivascular tissue and in the pia cells. Following injury to the brain fatty deposits are found in the glia cells. The present conception is that fat in the brain substance of the newborn child is always pathological.

The iron content of the fetus and newborn infant fluctuates considerably. During the first three months of intra-uterine life there is a gradual increase in iron in both the spleen and liver. Then follows a rapid increase to three times this amount in the fifth and sixth months, a drop to a medium position in the seventh and eighth months, and a rapid rise in the ninth and tenth months. This fluctuation is probably related to the action of the liver, spleen and bone marrow.

Initial Weight Loss.—In the last few years considerable work has been done on the prevention of initial weight loss by the use of complemental feedings and sugar water. While this loss can be combated by such methods, our observations have led us to believe that in a considerable number of infants this has reacted in a deleterious way. In those infants in which an attempt is made to maintain the birth weight there is a tendency for a prolongation of the period in which the so-called transitional, or better, irritative stool, appears. In some instances this has been so marked that the infants have developed what is known as an "initial diarrhea of the newborn." From these observations it would seem advisable to make no attempt to combat the initial weight loss unless it becomes unduly great. There is no particular reason in assuming that the birth weight of the infant must be regained upon any arbitrarily named day, and we feel that it is much better for the infant's bowel to be in a normal state with a delayed return to normal birth weight than to have the birth weight quickly regained at the expense of the intestinal tract. We have always felt and still do that too much importance is placed upon the weight of the child. Too often mothers are so insistent that their infants gain rapidly that the health of the child is jeopardized. Certainly during the first few days, when the infantile bowel is attempting to adjust itself to the presence of food, it would be far better to permit it to do so gradually rather than to overload it with nourishment. We still fail to see the necessity of the newborn's regaining its birth weight by the tenth day or of its maintaining its birth weight in the first few days.

PHYSIOLOGY OF THE BLOOD

Biologic Properties of Blood.—The work of Ratner and his associates relative to placental permeability leads to the assumption that the passage of heterologous substances through the placenta is physiologic and not pathologic. Placental permeability to antitoxins, precipitins, bacteriolysins and heterologous proteins and protein sensitizing antibodies occurs in man, guinea pigs and rabbits, but not in cows, goats and sheep. This difference of permeability is based on histologic differences of the placentas in these various species. Colostrum was found to play a negligible rôle in the transmission of protein hypersensitivity, and milk likewise plays a negligible part in the transfer of antibodies to the sucklings. Active sensitization of the newborn may occur *in utero* in animals, a fact which may explain the allergic manifestations of some infants to the first contact with a foreign protein. Passive sensitization acquired *in utero* is due to transference by way of the placenta and is not hereditary. These findings are contrary to the observations of others who found that placental transmission of antitoxic immunity was not as important as transmission by way of lactation. This school believes that fetal iso-agglutinin is not derived from the mother but develops in the fetus during intra-uterine life. Iso-agglutinins and agglutinogens may be formed after birth, usually by twelve days, and in some instances there is a definite change in blood groups in the course of two weeks (Mitchell). Some think that agglutinins follow the mendelian laws of inheritance rather than being affected by placental permeability. It is more than likely that the controversy has come about through the use of laboratory animals whose placentas do not conform histologically to the human placenta. At least one thing can be definitely learned from these studies, the presence of definite blood groups during the neonatal period makes it advisable to conduct the usual compatibility tests before resorting to transfusion.

The results of Blasi on the opsonic index in the newly born show that it is possible for the infant to produce antibodies even though their resistance in general to infection is poor at this age.

Icteric Index.—The icteric index in children is lower than that of the adult in which a bile index above five usually is to be considered abnormal. In newly born infants, however, because of the so-called physiologic jaundice, the index is high, probably rarely going below twenty. This is especially noticeable in the first week of life, following which there is a gradual decrease to the low point of the normal child after two or three months. This index has been found to be high, often up to thirty, even when no clinical jaundice is noticeable. As one would expect, prematurity favors an increase in the icteric index. For those who are interested in methods of estimating the icteric index the capillary method devised by Davis is fairly accurate.

Inorganic Blood Phosphorus.—The inorganic blood phosphorus of the newly born infant is low, ranging from 3 to 5 milligrams per 100 c.c. of blood. The work of Brunn definitely confirms the report of Hess that there is a seasonal variation in the phosphate level of the blood in older infants. There is a pronounced sag in the curve during the first three or four months of the year. Freund and Schmitt found that irradiation by ultraviolet light during pregnancy caused a slight increase in the blood phosphorus of the infant, and a decrease in the signs of rickets.

Leukocytes.—After the first ingestion of food there are no numerical changes in the leukocyte count in newborn infants. The second day after alimentation is started leukocytic variations, especially a leukopenia, are found. In debilitated and premature infants there is a delay in the post alimentary changes. Sanford has found that short exposures of ultraviolet rays increase the number of young or single-lobed nucleated cells of the polymorphonuclears. Cessation of exposure causes a rapid return to normal.

Blood Platelets.—The blood platelet count according to Farnos' method was found to be from 100,000 to 200,000 during the first day of life, and from 170,000 to 270,000 from the fifth to the seventh day, and from 250,000 to 350,000 in the third week. These counts follow rather closely the curve of the coagulation time during the first days of life, and confirm the counts of previous investigators.

Erythrocytes.—Sanford has shown that short exposure to the ultraviolet light increases the hemoglobin content and the number of red corpuscles of the blood of newly born infants, especially in those infants whose hemoglobin and red cell content are lower than normal. Study of the living blood cells of the newborn by the supravital method shows very little difference in the percentage and number of the various blood cells as compared with counts obtained by ordinary staining methods.

THE STOOLS

Classification.—The usual classification of stools during the newborn period into meconium, transitional and milk stools is purely a chronologic classification. It is difficult, indeed, to find the end point of the stools so classified. The meconium is usually excreted during the first three or four days of life, but frequently certain characteristics appear early which indicate that the bowel is being affected by something of an irritative nature. These stools are characterized by the presence of mucus, the appearance of a slight odor, and definite softening of the feces, all evidences of intestinal irritation. When the irritative process becomes more advanced the so-called transitional stool appears and if it progresses initial diarrhea occurs. This has always been considered merely a stool which completes the transition from the meconium to the milk stool. Close observation will reveal the fact that this transition period varies greatly in length, and that while usually by the fifth or sixth day the stool appears yellow, evidences of irritation are still present, and not for some time does the true milk stool appear. It seems more appropriate to call this stool which shows definite evidence of intestinal irritability the *irritative stool.* As long as there are manifestations of irritation present, the stool should not be considered a normal milk stool. There is little reason to doubt that the explanation of these irritation products lies in the presence in the intestinal tract of inflammation either from bacterial invasion, irritation by products of digestion, or both. Although this process occurs so constantly that it is ordinarily considered physiologic, upon closer investigation it cannot be so considered. It is similar to pathologic conditions which occur in other parts of the body at this period. For instance, it may be likened to the catarrhal inflammations of the vagina and nasopharynx which are seen shortly after birth and which are due to primary bacterial invasion. As we have mentioned before, these stools are closely related to the initial diarrhea of the newborn.

Blood in Stools.—Mention has been made from time to time concerning the presence of microscopic and occult blood in the meconium period. But little mention has been made of the frequency of occult blood in the later stools of the newborn. Ratnoff, Snapper and van Creveld, Raiz, and Bonar have been able to demonstrate the presence of occult blood in from 30 to 50 per cent of the stools. The fact that these babies were apparently as normal as those who showed no blood in the stools led to the conclusion by some that the bleeding at this period might be considered physiologic. However, examination of the intestinal tracts of infants dying during the course of these studies showed a definite hyperemia, especially in the small bowel. This hyperemia is probably another manifestation of the irritation of the intestines by products of digestion, bacterial invasion, or both, and occurring at a time when it is known that there is a prolongation of the bleeding and coagulation times of the blood this would favor the loss of blood from the involved area of bowel. Later studies by one of us seem to indicate that those infants passing frequent stools of the irritation type are more prone to show blood in the feces. This is merely further evidence that the presence of blood should not be considered a physiologic but a pathologic condition due to bowel inflammation.

Bacteriology of Stools.—A study of the anaërobic intestinal flora by Upton has furnished a few interesting points in the bacteriology of the intestinal tract. As long as the meconium persists various organisms are present which disappear under breast feeding as the *Bacillus bifidus* becomes predominant, usually by the fourth or fifth day. The sudden predominance of this organism would indicate some relationship to the establishment of the milk diet. Gas bacilli occur in about 50 per cent of the stools, tending to disappear as *Bacillus bifidus* gains the ascendancy. The intestinal flora of the artificially fed infant resembles that of the breast fed infant of two or three days, that is, when the meconium flora is present and only a few *Bacillus bifidus* organisms have appeared. Such stools exhibit great variety as compared with those of the breast fed infant.

METABOLISM

Carbohydrate Metabolism.—The work of Greenwald and Pennell on carbohydrate metabolism of the newly born infant corroborates previous findings of Benedict and Talbot that there is no relation between variations in the weight and blood sugar concentration. An increase in weight is not necessarily accompanied by a rise in blood sugar, nor is a lowered weight necessarily paralleled with a drop in the blood sugar. After breast feeding during the first forty-eight hours of life no increase in the blood sugar concentration occurs, probably due to ingestion of an insufficient amount of breast milk during this period, but after two days a definite rise occurs in the blood sugar concentration in from one-half to one hour in nearly all the infants. The best tolerance is for lactose as it occurs in breast milk. The best rate of absorption occurred after the ingestion of dextrose, saccharose, lactose, and dextrimaltose in the order named.

Synthesis of Fats.—Regarding the infant synthesis of fat, Wesson is of the opinion that the fetus is able to synthesize fatty acids in amounts sufficient to satisfy its own requirements.

Insensible Perspiration.—The work of Levine and his associates on the insensible perspiration shows that infants less than one year of age maintained an average basal rate of loss of 1 gram per kilogram per hour. There is a rise in insensible perspiration proportional to the increase of body weight and to the age of the child. The consistent results they have obtained have led to the introduction of tentative standards and normal limits of variation for this measurement in infants on the basis of age, weight, height and surface area.

SECRETIONS

Cerebrospinal Fluid.—The cerebrospinal fluid of the newborn has been extensively studied in the last few years and there is some conflicting opinion regarding the success of lumbar punctures at this age. Sharpe has been able to obtain spinal fluid with relative ease, whereas Waitz and others have not been able to do so. The latter even goes so far as to believe that the appearance of fluid at puncture should be considered pathologic. This view one would hesitate to take. The most frequent cause of unsuccessful lumbar punctures is the pushing forward of the loosely attached dura of the posterior wall of the spinal canal by the needle, and unsuccessful punctures will occur less frequently if the tap is made with the child in the upright position. Xanthochromia is not pathognomonic of hemorrhage and still is considered more or less physiologic at this age. The yellow color of the cerebrospinal fluid appears to be due to bilirubin, since frequently a positive indirect Van den Bergh reaction can be demonstrated, but the color is more likely due neither to hemoglobin nor to bilirubin but probably to pigments intermediate in composition between these two. The use of cistern puncture is more reliable for the purpose of obtaining fluid than the lumbar puncture, and is relatively safe. The appearance of blood corpuscles in the spinal fluid of the newborn infant is not uncommon, and crenated cells are not uncommon. The globulin tests are positive frequently in as high as 50 per cent of the fluids. Levinson found the fluid pressure by cisternal puncture to average 25 millimeters of mercury as compared with an average of 4.5 millimeters of mercury by lumbar puncture.

PHYSIOLOGY OF THE URINE

The investigations of Faerber and de Boutemard revealed the presence of albumin casts and leukocytes in all specimens of urine in the first three days of life. There was a variation in these constituents after this time according to the fluid intake of the infant. When the fluid intake reached a satisfactory level the urine became clear, suggesting that the albuminuria of the newborn is due to dehydration.

PHYSIOLOGY OF THE NERVOUS SYSTEM

Embrace Reflex.—The embrace reflex described by Moro is obtained by placing the infant on a table and forcibly striking the table on either side of the child. A motor reaction is obtained in which the arms are suddenly thrown out in an embrace attitude describing an arc and tending to approach one another with a slight tremor. The fingers are at first spread and then closed. Movements of a lesser but similar nature are observed in the lower extremities. This reflex is explained on the basis of an atavistic attribute and is found in those nursling animals which are carried about by their mothers. It is an unconditioned reflex most noticeable in the first two months of life, diminishing in intensity from then on, and disappearing at the end of the fourth month. It is a symmetrical reflex, the absence on one side indicating either motor paralysis or injury on that side. Severe cerebral injury and general weakness diminish the intensity of the response during the first few weeks. According to Gordon, persistence of the Moro reflex in children above the age of six months signifies injury to the cerebrum or pyramidal tract. This reflex is similar in many respects to the grasping and groping fear reflex, but in this instance the attitude assumed is one which occurs in crying, and there is an expression of fear on the face.

Conditioned Reflex.—The conditioned reflex can be developed in the newborn with comparative ease, but its use under ordinary circumstances is purely academic. The practicability of using this reflex to determine the ability of a newborn to hear has been used by Aldrich for the purpose of advising the adoption of a newly born infant. At half hour intervals a bell was rung, while at the same time the sole of the foot was scratched with a pin. After twelve or fifteen such applications the infant cried and drew up the leg when the bell was rung and the foot not touched. This furnishes us with a definite method for determining the presence or absence of hearing. Without doubt many other equally as good practical applications of this reflex could be found.

Chvostek Phenomenon.—Stevenson and his associates have found that Chvostek's sign occurred consistently in normal newborn infants, especially during sleep. In crying or restless infants it was never obtained. This phenomenon was found to be present when the blood calcium determinations were within normal limits and the electrical reactions within normal limits. It cannot be regarded as a symptom of tetany in the newborn.

FEEDING

Importance of Water.—In the early care of the newborn infant it is extremely important to emphasize the necessity of water in order to prevent as much as possible the development of certain symptoms of dehydration such as inanition temperature with its symptoms of acidosis in the late states. Early and frequent administration of fluids will serve to reduce the incidence and severity of inanition fever, serve to reduce the amount of initial weight loss and tend to reduce the tendency for the appearance of albumin and casts in the urine.

Density of Curd.—Very little information is at hand regarding the character of the curd of breast milk. At the present time there is a tendency in some parts of the country to ascribe certain digestive disturbances to the hardness and tenacity of the curd of cow's milk. The work of Brennemann concerning the size of the curd is well known, showing that the process of boiling milk reduces the size of the curds formed. Little has been done however in this respect with human milk, but a recent method of estimating the hardness of the curd of cow's milk should encourage a similar testing of breast milk (Hill). Whether or not curd hardness has anything to do with gastro-intestinal disturbances of infancy and childhood has not been clearly shown as yet, but if there is any proof to be had in the next few years, similar studies should be made with human milk, for it is well known that the milk of certain mothers seems to upset the digestive functions of the offspring.

Lactic Acid Milk.—The use of lactic acid milks which have been the vogue for some time, while based on sound physiologic principles, will probably suffer a decline in the next few years in view of the experiments of Brennemann who has shown clinically that infants fed on evaporated milk without the addition of lactic acid gain and thrive as well as those fed on the lactic acid evaporated milk combination. This work corroborates an early investigation of Grulee on the results obtained in an infant welfare clinic in which no acid milk feedings were used.

Dried and Evaporated Milks.—The use of powdered milks and evaporated milk has increased in the last few years, and to all intents and purposes it seems to be about as efficacious as fresh milk. In some respects these preparations are to be preferred, especially where it is impossible to obtain a uniform, clean milk, and where the conditions under which the milk is to be prepared for the infant are such that the cleanliness and ability to preserve the milk are doubtful.

Antirachitics.—Cod-liver oil has been used for years for the prevention and cure of rickets. Lately it has been found that ergosterol, which is generally inert in nature, carries the active antirachitic vitamin D present also in cod-liver oil and egg yolk. Steenbock and Hess have been able to activate ergosterol by irradiation, and now a substance known as activated ergosterol may be obtained commercially. This substance is standardized to 100 times the activity of cod-liver oil in vitamin D. It must be remembered, however, that it contains no other properties of cod-liver oil. The dosage is small, ranging from six to ten drops a day. Many other food substances have been irradiated and found valuable in the prevention of rickets but ergosterol is by far the most commonly used. One must not forget that cod-liver oil and egg yolk are antirachitics, and they will continue to be used by a large majority of mothers.

Sun-baths, ultraviolet ray therapy, are all valuable in the prevention of rickets. In localities where there is very little sunlight during the winter months the latter may be used. It is necessary to sound a warning against too enthusiastic use of the antirachitics. The literature now occasionally mentions cases of hypercalcemia resulting from overtreatment.

PREMATURITY AND CONGENITAL DEBILITY

Prematurity and congenital debility are still a problem of great interest to the pediatrician, as can be noted by perusal of the medical literature on this subject for the last few years. Some of the older and more complex methods of caring for these infants have been abandoned for the simpler methods and especially is this noticeable in respect to incubators and other devices to maintain constant heat.

Estimation of Fetal Age.—Estimation of fetal age is extremely difficult. Little new knowledge has been added to this subject. Bischoff has recently used a modification first described by Korber which ascertains the resistance of the hemoglobin to alkalies in order to determine the age of prematurely born infants, and also to decide during the first year of their life the time of conception of these infants, matters of importance in connection with foundlings, illegitimacy, and questions of parenthood. The age is learned to within a few weeks. Fetal hemoglobin has been found to be more resistant to the action of alkali than the hemoglobin of adults, and that of the prematurely born infant is much more resistant than that of an infant of the same age born at term. These tests can be employed with hemoglobin decomposed or dried blood which has been kept several years. Finkelstein and Wilfand have described a new sign of prematurity which consists of placing the body in the lateral recumbent position when two sharply symmetrical halves of different color are noticeable. The underlying half is red, tinged with blue; the upper half is pale or white; the line between is precisely the median line, and there is no gradual transition from one to another. The picture can be reversed by turning the child over to the other side. The phenomenon lasts for about two months.

Parmelee after examination of many full-term and premature infants is persuaded that the absence of mammary gland tissue is one of the most dependable signs of prematurity.

Blood Counts.—The work of Herz and Schmal and his associates on the white blood cell content gives higher figures than previously noted, ranging from ten to twenty thousand. The differential count showed a predominence of lymphocytes with a shifting in all cases toward the granular type of cell. Their studies on the erythrocytic count showed the usual polycythemia during the first days and their hemoglobin estimations compared favorably with those of earlier writers.

Low Birth Weight.—Pulford and Blevins report the survival of an infant weighing 680 grams at birth. At the age of three years the girl is apparently normal both physically and mentally.

Fate of Premature.—Capper has rendered a great service in the study of the fate and development of the immature and of the premature child in a study of 437 children who weighed less than 2500 grams at birth. The mortality of immature infants is high, 40 per cent of those whose birth weight is under 1000 grams dying in the first twenty-four hours, while only 1.5 per cent of those weighing between 2000 and 2500 die in the first twenty-four hours. Only 55 per cent are alive at the end of the first year, and 52 per cent at the end of the fourteenth year, a fact which shows that the critical period for the immature child as far as survival is concerned is the first year of life.

Intracranial hemorrhage is the most common cause of death during the first week of life, due not only to the direct mechanical trauma of birth, but also to the vasolability of the infant which in turn is due to the persistence of the fetal type of capillary and the incomplete development of the vascular elastic tissue at this age. Of those who survive the first year the majority remain underweight and below normal height even at the age of puberty. The chief cause of subnormal height is the delay of growth of the extremities rather than the trunk. The skull of the immature child outside of the relative megacephaly of the first eight months of life remains undersize up to twelve years of age, and especially is this so during the first six years of life. The chest circumference is smaller in immature children up to the fifth year, after which it becomes above normal until past puberty. The larger number of immature children, especially boys, are of the asthenic and adenoid type, with long trunks and short extremities and a moderate or small deposit of subcutaneous fat. They are usually hypotonic. The static functions, such as sitting and standing, are delayed, and defects in speech are frequent. Only one third of the immature children of school age were in classes corresponding to their age, and 11 per cent were in schools for the subnormal child.

Epilepsy, Little's disease, idiocy and imbecility, and enuresis were more frequent than among mature children, and neuropathy was especially frequent. The development of signs of puberty were not retarded. Congenital cardiac defects were more frequent and dental defects and retardation were common, probably the result of the early presence of rickets.

After the first year of life the immature child seems to resist infections in a manner similar to that of the mature child. Tuberculosis is not more frequent.

Capper concludes that the fate of the immature child is not enviable as almost one-half of them die during the first year of life, and of those remaining alive the majority are physically as well as mentally underdeveloped. Some of them show a late mental development, others show a condition of psychic infantilism, while still others show permanent and severe mental disease. In brief, the immature infant becomes the backward school child and is potentially a psychopathic or neuropathic patient, or the potential candidate for a home for the feeble-minded. This problem is an important one and all possible efforts should be directed not only to the care and preservation of the immature child, but more particularly to prenatal care, prevention of maternal infection, and correction of all possible anomalies of the birth passages before pregnancy. The results of this study are pessimistic to say the least, and one wonders whether or not the great exertions upon the part of the attendants is worth the effort extended to the child under 1000 grams when the fate of the infant is such as it is. Yet, no doubt all of us can cite instances of normal individuals who were of this extremely small size, and a glance through the history of the world will show that many of its greatest figures were of this class. Perhaps the genius of these great figures in history was due to an abnormal mentality, resulting from the cerebral sequelæ caused by their premature births.

However, Capper's investigations were made upon a series of children who were probably not given the individual care and attention described by Hess, whose series of 266 cases were cared for in his clinic. He states that at the end of two years these children as a group resembled full term infants in physical and in mental development. There were no apparent mental defectives in this group. Nevertheless, if one were to study these children the world over the findings of Capper would be more nearly correct. Hess' observations, which are similar to those of many of us connected with institutions where organized and individual treatment can be given these infants, merely emphasize the great necessity for better obstetrics and more interest and detailed care of the premature infant if it is to be given every opportunity possible for life and normality.

Feeding.—Our results following the feeding of premature infants at four hour intervals in the last few years strengthens our convictions upon this subject to a far greater degree than ever before. At present we see no reason to return to the habit of feeding these infants at more frequent intervals. When artificial feeding is necessary albumin milk is still the food of choice with us. Chymogen milk has been highly recommended by some observers because of the fine size of the curds.

Antirachitis.—The use of irradiated ergosterol as an antirachitic is certainly to be advocated since it is much more potent in the antirachitic factor than the ordinary cod-liver oil, and as a result can be given in much smaller doses. Depending somewhat upon the size of the infant and the season of the year, the dosage is from 2 to 5 drops three times a day. During the summer months the dosage of this preparation may be reduced considerably, and sun-baths instituted.

ASPHYXIA

The last few years have ushered in a more sane and effectual conception of asphyxia and better methods of handling the asphyxiated infant. For years many have deplored the old-fashioned methods of severe cutaneous stimulation. When a case of asphyxia in the newborn presents itself one must always think of the possibility that several causes of asphyxia may be present at the same time. Such causes may be loss of irritability of the respiratory center; weak thoracic muscles; aspiration of amniotic fluid or meconium; and finally cerebral hemorrhage. Treatment consists of removal of obstructive material from the mouth and throat by means of a catheter, followed by administration of warmth and by rubbing or gently tapping the body. If the child begins to breathe one should do nothing but observe it closely. Further efforts at resuscitation should be based upon the modern conception of the regulation of respiration by the action of the blood gases on the respiratory center. Deficiency of oxygen after a first slight stimulating effect causes depression of the nerve centers. In the absence of oxygen the tissues of the body cannot produce carbon dioxid which is the physiologic stimulant to respiration. When the center is depressed it requires more than the normal amount of this stimulant to induce activity, and similarly any lack of oxygen such as may be present in the newborn will reduce the amount of carbon dioxid naturally formed so that this deficiency must be made up artificially. Compression of the head, with resulting decrease of the supply of blood to the brain during prolonged labor, depresses the respiratory center to such an extent that after delivery it does not receive a chemical stimulus sufficient to overcome this depression. This condition of the center is responsible for failure to breathe, and the lungs remain atelectatic. In order to start respiration gentle inflation with oxygen and carbon dioxid for 2 or 3 seconds three or four times a minute should be instituted until full breathing is established. This method is not only physiologic but is really the best and only possible method to be offered (Henderson). In some instances it is necessary to use 5, 10 or 15 per cent concentrations of carbon dioxid. Devices for the administration of oxygen and carbon dioxid are now on the market and should be part of the equipment of every obstetrical department.

It must be remembered that since asphyxia may be one of the symptoms of intracranial hemorrhage that use of more strenuous methods may have a damaging effect upon the infant suffering from this type of condition. Therefore, the measures mentioned above are desirable if for no other reason than their gentleness.

Drug Therapy.—Little change in the drug therapy of asphyxia neonatorum is to be offered. The use of alpha-lobelin in 0.5 c.c. to 1.0 c.c. doses into the umbilical vein or intramuscularly has resulted in some instances in the onset of respiration within a few seconds after injection. The drug contains the active principle of lobelia and pharmacologically is said to act by stimulation of the respiratory centers in the same way as carbon dioxid. In our hands this preparation has given variable results but its use is well worth while.

Electrical Stimulation.—The use of the faradic current for resuscitation as advocated by Israel in an attempt to stimulate the phrenic nerves has not been investigated sufficiently to warrant any conclusions.

CYANOSIS

Limited or Localized Cyanosis.—The commoner causes of neonatal cyanosis are those due to mechanical blocking of the air passages, and injuries of the central nervous system. These have been fully covered in Volume II, Chapter XIV. There are forms of cyanosis which are due chiefly to obstruction of some sort in the flow of blood either through the heart or through the great vessels. Thus, Sahler describes a case in which the cyanosis was confined to the face and neck, and was first observed ten minutes after birth. Roentgenological examination a few hours later disclosed a distinct widening of the shadows of the great vessels during inspiration and expiration. The cyanosis and increased shadows diminished and had disappeared by the third day. Sahler explains this condition as due to disturbance of innervation or sluggish action of the right auricle with overfilling and compression on the superior vena cava, or obstruction of the orifice of this vessel by a projecting tuberculum intervenosum. We have recently seen a case very similar to this one which appeared at birth and lasted for three days. Thinking that perhaps the pressure was due to thymic enlargement, a roentgenogram was taken which showed only moderate increase in the width of the shadow of the great vessels.

TRANSITORY FEVER

Very little has been added to the subject of transitory fever of the newborn. The condition is still considered dependent chiefly upon dehydration, but one must bear in mind always the possibility that cerebromeningeal lesions, the result of birth trauma, may play a part in the causation of such fever. In view of the fact that the time of appearance of transitory fever is coincident with intracranial complications, bacterial invasion of the mucosal surfaces of the body, and the appearance of icterus neonatorum makes it difficult to ascertain definitely the causative factor. In an earlier study we were unable to find a regular relationship between this type of fever and the quantity of fluid ingested, which led us to think that the condition could possibly be based on the bacterial infection of the bowel contents during this period. Further studies of the stools during this period have shown that there is a definite hyperemia of the bowel lining, probably from bacterial invasion, to such an extent that blood is found in the stools in a large number of cases. This leads us to the conclusion that perhaps bacterial invasion plays even a greater part than previously assumed in the development of inanition temperature.

ICTERUS

Hematogenous Origin.—Icterus neonatorum has been the subject of much investigation in the last few years, but as yet the subject is far from closed. With the development of van den Bergh's test which attempts to differentiate between the hematogenous and hepatogenous origin of jaundice, it has been shown that the icterus of the newborn is of hematogenous origin. Grulee and Mebane have raised some doubt as to the value of this test. During the first days of life there is a marked diminution in the erythrocyte count due perhaps to some hemolytic agent in the blood stream. The destruction of the red cells results in an increase in free hemoglobin or some of its degenerative products in the blood stream. Since the bile pigments are formed from such products, it is only natural that the bile index at this time should be high, and such is the case. The icteric index of the newborn infant in the first week or two of life is high, probably rarely if ever running below 20. It is important to remember that while clinical jaundice is not evident in more than 25 to 30 per cent, the bile content of the blood is high in all these infants.

Theories.—The presence of icterus in the newborn is coincident with the disappearance of polycythemia, the gradual disappearance of immature red cells, which in turn probably accounts for the increased fragility of the red cells, and the presence of indirect van den Bergh reactions and a constant increase of the icteric indices. All of these go to prove that icterus neonatorum is of a hemolytic nature, and some have claimed the presence of a hemolysin in the maternal blood. Goldbloom and Gottlieb could not confirm the presence of a hemolysin and believe that the presence of hemolysis is due to fragility of the immature red cells which are present in such large numbers. The polycythemia of the newborn is explained by them on the basis of the need of the fetus for oxygen because of the lack of pure arterial blood in the circulation. The fetus therefore lives in a condition of oxygen deficiency and probably is cyanotic. Soon after birth anoxemia no longer exists because of the institution of respiration, the necessity for polycythemia ceases, the excess of red cells disappears and icterus results.

Mitchell takes an opposite stand that the blood serum of the mother contains a substance capable of hemolyzing the red blood cells of her infant *in vitro*. This substance was demonstrated in 51 per cent of the infants studied. He does not consider that increased fragility is a factor in the production of jaundice.

Incompatibility.—Smith presents evidence to show that interagglutination may serve as an excessive factor in the production of this condition. Icterus appeared more often when the blood group of the mother and the newborn infant did not match.

Icterus Gravis.—Hoffmann and Hausmann draw attention to the fact that infants with severe forms of icterus neonatorum frequently have associated symptoms of injury to the brain. This is probably the result of an increased coagulation time during the icteric period with more massive hemorrhage in those cases in which there is intracranial injury. Greenwald and Messer report similar involvement of the nervous system in a severe case of familial icterus neonatorum gravis with recovery. The question of familial icterus neonatorum is extremely interesting. Frequently several children in one family die shortly after birth from this condition, and no apparent cause as far as the condition of either parent is concerned can be found. The presence of an hemolysin of some sort must be considered for there appears an anemia in a great number of these children. In a recent case of ours which died the red cell count dropped from over 5,000,000 to 900,000 in the course of a week, and the hemoglobin from 110 to 18 per cent. The icterus disappeared rapidly with the development of a severe anemia. Three other children of these parents died of the same condition.

Buhrman has recently had a case of congenital jaundice. The child was born with a severe jaundice and likewise with a severe anemia. One of the interesting features is that the child had 200,000 nucleated red cells and 250,000 white. The jaundice increased up to the fifth day when it gradually subsided, so that at the time of death, on the thirty-second day, only a slight icteric tint remained.

Cameron, in the Ingelby Lectures, calls attention to the success of Hampson in the treatment of the grave familial jaundice of the newborn by means of repeated intramuscular injections of the mother's serum. In the family study there had been 75 fatal cases of jaundice and 15 survivals. Since treatment in the same families there have been 18 cases of this hitherto so fatal jaundice, with 17 recoveries.

HEMORRHAGIC DISEASE OF THE NEWBORN

Relation of Anesthetics to Bleeding.—The question as to whether the anesthetic given during delivery plays any part in predisposing the infant to hemorrhage has shown little with respect to the use of ether and chloroform. Sanford has recently found that nitrous oxide gas caused the prolongation of the average bleeding time at birth of one minute, and the coagulation time of two minutes. Ethylene was found to prolong the bleeding time two minutes and the coagulation time three minutes. At the end of nine days in both instances they became practically normal.

Relation of Asphyxia to Bleeding.—Doubt as to whether asphyxia plays a part in the development of hemorrhage in the brain has been brought forward by Ford who was unable to produce brain lesions in animals by the employment of various types of experimental asphyxia.

Prophylaxis.—In the prophylactic treatment of hemorrhagic disease of the newborn Kugelmass and Tritsch found that the clotting components of the blood during pregnancy in a woman who had lost several infants from melena neonatorum showed prothrombin deficiency analogous to that in true melena neonatorum. Institution of nutritional therapy throughout pregnancy produced and maintained normal maternal blood before birth, with the resulting delivery of a non-bleeding infant. Avitaminosis as a cause of hemorrhage of newborn animals has been demonstrated on experimental animals. Moore and Brodie have reported a case of hemorrhage in the newborn in which the prenatal diet was markedly deficient in water soluble vitamin B. Such scattered reports seem to emphasize the fact that prenatal diet may play a part in the causation of hemorrhagic disease and should lead to more care of the dietary of the pregnant woman.

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THE NEWBORN —
DISEASES AND ABNORMALITIES

SUPPLEMENTARY CONTRIBUTION

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WINCKEL'S DISEASE

There has been scant mention of Winckel's disease in the last few years. Feldman described such a case in which the picture was very similar to that given by Winckel. The results of autopsy were entirely negative, and no organism could be incriminated. This condition is so closely associated with sepsis neonatorum that we question whether or not it should be considered a disease entity. The symptoms and findings can be easily ascribed to a terminal sepsis.

INFECTIOUS DISEASES

Immunity.—The subject of susceptibility and immunity of the newborn to disease continues to be of great interest to the medical profession, and there is still a great deal of difference of opinion concerning it. The newborn is particularly susceptible to infections of all sorts, especially those caused by pyogenic bacteria. Prematurity, congenital debility, nutritional disturbances, all favor the development of infection, and similarly susceptibility to infection is increased by abandonment of breast feeding. The bactericidal power of the serum of the breast fed infant has been repeatedly shown to surpass that of the artificially fed infant, either because of protection transmitted by the mother's milk, or because breast milk is a natural food and stimulates the production of protective substances by the organism itself. The question as to whether immunity is transmitted through the placenta or by the breast milk has been the subject of considerable controversy, and at the present time some of the more thoroughly controlled experiments seem to point to the fact that the placenta is permeable to antitoxins, precipitins, bacteriolysins, and heterologous proteins. The fact that placental permeability varies considerably with the species, probably accounts for the difference in findings by various observers using different experimental animals. Ratner and his associates are of the opinion that in man such permeability is present, and that breast milk is a negligible factor in the transfer of antibodies to the newly born infant.

The possibility that the newborn infant may develop its own immunity to some extent must be considered, and there is no reason to suppose that such is not the case. The degree to which this occurs, however, must, because of the well-known virulency of neonatal infections, be small. The work of Blasi on the opsonic index in the newly born infant shows that it is possible for it to develop antibodies in spite of its lowered resistance to infection in general.

Characteristics of Infection.—The characteristics of septic infection in the newborn are based to a large extent upon its lack of resistance, and because of this there is often very little reaction upon the part of the infant to infection. Thus, a generalized infection often occurs without visible involvement of the lymphatic system and lymph-nodes or localized skin reaction. Frequently the infective symptoms are completely obscured by the signs of toxemia so that there is no definite indication of the original site of the infection or where the secondary metastases are. The infant is frequently afebrile and apparently in fairly good condition within a few hours of death. Suddenly terminal symptoms occur such as coma, convulsions, diarrhea, hemorrhage, and collapse. The frequency with which hemorrhage occurs in sepsis of the newborn has led to the attempt by various observers to make clinical entities out of terminal symptoms. It is not unlikely that the diseases known as Buhl's and Winckel's belong in this category.

Sepsis Neonatorum.—Sepsis neonatorum still offers those who are interested in the diseases of the newborn much opportunity for study. The portals of infection are many, so many in fact that there is little need to wonder why in a given case the starting point cannot be found. The most common atria are the respiratory tract, gastro-intestinal tract, and the umbilicus, but undoubtedly many of the obscure infections during this period may be due to an inconspicuous otitis media. From an etiological standpoint some of these infections may occur *in utero,* the result of maternal infection. The influence of such infections as tonsillitis, nasopharyngitis, pyelitis, and endocarditis in the mother upon the offspring has received too little attention. The transmission of general infection through the maternal blood vessels to the circulation of the fetus is entirely possible, and probably occurs much more frequently than we have been led to suppose. Certainly nearly all known specific diseases have been so transmitted. All such possibilities emphasize more than ever the value of prenatal care (Duskes and Dodge). Another etiologic factor in the production of sepsis in the newborn is maternal toxemia. There is considerable reason to believe that the toxemias of pregnancy play a not inconsiderable part in lowering the resistance of the offspring to infection.

The treatment of sepsis neonatorum is chiefly prophylactic. Conscientious prenatal care with particular effort at eradication of focal infections, strict asepsis during and after delivery, prompt isolation of all infants in whom there is a suspicion of infection, and avoidance of trauma to the newborn during delivery, together with institution of every possible precaution in the prevention of contamination of the newborn infant by attendants, is the only way in which the incidence of sepsis can be reduced. The active treatment is as yet far from being successful.

Erysipelas.—In the last few years a commercial antitoxin has been developed for use in the treatment of erysipelas which has been sufficiently efficacious to warrant its use in the treatment of erysipelas of the newborn. The dosage in the newborn infant is from 2000 to 5000 units, depending upon the severity of the disease. In our hands this serum has been of considerable value, but if convalescent serum may be had the results obtained from its use may be even better. From 10 to 15 c.c. of the convalescent serum should be administered subcutaneously once or twice a day, depending upon the progress of the disease, until it shows definite signs of subsiding. Blood transfusion is a useful procedure.

Smallpox.—Martin reports a case in which twins were born during the second stage of a severe maternal smallpox. Both of the infants were in the papular stage of the disease, and both the mother and the infants recovered.

Diphtheria.—Diphtheria in the newborn is notably a mild infection, perhaps because of a partial immunity which protects the infant against this disease. The fact that the symptoms are so mild may lead to a failure to diagnose the condition. Parigl reports four cases of diphtheritic rhinitis in whom the symptoms were extremely mild, all of which promptly recovered following serotherapy. He urges frequent recourse to bacteriological examination of infants with rhinitis which seems to be refractory to ordinary treatment. The fact that diphtheria is frequently found when looked for leads one to assume that many cases are missed.

Montgomery has seen a case of diphtheria of the umbilicus complicated by postdiphtheritic paralysis and myocarditis with death at 43 days of age. He records the report of 42 cases of diphtheria infection of the umbilicus. Diphtheria in the wound of a ritual circumcision has recently been seen by one of us. The condition is quite rare but should be remembered in lesions with membrane in this region. In the case mentioned the membrane was typical and detached promptly following injection of antitoxin.

Measles.—Congenital measles is probably more frequent than one would suppose. Undoubtedly the natural immunity which some children seem to possess can be explained in this way. If maternal measles occurs before term and does not result in premature labor, while it is impossible to know whether the child born later has had intra-uterine measles, such is probably the case. Furthermore, the possibility of atypical manifestations in the prematurely born infants must be considered. The usual absence of coryza and conjunctivitis may be due to the fact that the portal of entrance in such cases is the blood stream rather than the upper respiratory tract. It seems peculiar that there is such a paucity of reports of congenital measles. Debre cites a case in which the mother was exposed to the disease a day or two before delivery. Ten days after exposure measles developed, and in spite of a prophylactic injection of a small amount of convalescent serum the baby developed measles three days after the mother. One of us has recently seen a premature infant born with measles during the eruptive stage in the mother. This infant showed an atypical but, nevertheless, well-defined measles exanthem without catarrhal symptoms. As far as the treatment of infants exposed to measles is concerned the use of convalescent serum in quantities of 10 to 15 c.c. is of definite value in prevention, provided it is given within two or three days after exposure. Otherwise, a modified form of measles will probably develop. The use of whole blood of the parents, assuming that they have had measles at some time or other, is a valuable procedure in the production of immunity to measles or modification of measles, and is heartily recommended. The dosage in newly born infants is 15 to 30 c.c. The blood can be given by the direct method.

If human serum is not available one should try Tunnicliff's serum.

Scarlet Fever.—Scarlet fever is infrequent in the newly born infant, so much so that there is some question as to whether it occurs.

Application of the Dick test to both mothers and newly born infants would seemingly settle this question. Unfortunately, in our experience, which is similar to that of others, the reactions upon the part of the infants are so irregular that little information of value can be obtained. Cooke believes this is due to a lack of sensitiveness of the skin of newly born infants to scarlet fever antitoxin, and is not an indication of the presence of any antitoxin. If by chance a case of scarlet fever were to appear, the use of a small amount of scarlet fever antitoxin·would seem justifiable, especially if the symptoms were severe and the rash definite and typical. It must be borne in mind, however, that the action of this serum is sufficiently severe to warrant a correct diagnosis before using it.

Influenza.—Influenza has not been of such frequency and severity in the last few years as to furnish many reports about its presence in the newborn infant. Rosenbaum mentions a condition which he describes as morbilliform influenza in five infants, with a terminal streptococcic sepsis in four. The rash resembled that of measles somewhat, but the absence of conjunctivitis and Koplik's spots, together with the isolation of influenza bacilli in three of the cases, led him to think that the condition could not be measles. However, measles is so atypical in the newborn that absence of these symptoms might occur, and due to the fact that influenza bacilli are commonly found in measles it does not seem that the diagnosis is clearly justified.

Gonococcus Infections.—A few reports of gonococcus infections in the newborn are at hand, all of which refer to joint involvement (Yoksitch, Wahlberg and Knauer). In some there appeared to be no portal of entry, while in others gonococci were found in the smears from the eyes and nose. The ultimate results in all were uniformly good.

Cooperman reports an epidemic of 67 infants infected with gonococcus, 53 of which presented joint complications. Multiple arthritis was the rule in 75 per cent of the cases, and two types were noticed. One, accompanied by swelling and tenderness, suggesting suppuration, and the other, a subacute synovitis with effusion. Infantile joints in spite of suppuration appear to display a marked resistance to the infection with the result that ankyloses are rare. Hip-joint infection gave the poorest prognosis. In those cases in which there is no apparent portal of entry the rectum may serve as an atrium. The organisms may invade the blood stream shortly after local implantation and rapidly metastasize to predisposed joints. The appearance of an epidemic of this enormity in a maternity hospital only goes to show that hospitals must ever keep an unceasing vigil for possible sources of gonorrheal infection. The periodic examinations of attendants, and routine bacteriologic examinations of expectant mothers, are of prophylactic value, but, even so, occasionally the disease may appear. Prompt isolation of suspicious patients will go far toward the prevention of such outbreaks.

Tetanus Neonatorum.—This disease occurs with much less frequency than it did years ago. Cameron mentions a fact which may explain to some extent the frequency of this condition in olden times. In certain cases of sepsis neonatorum in which tetanus is not present there is a muscular rigidity with trismus which might lead a clinical observer to diagnose tetanus in the absence of bacteriologic proof. The rigidity of the jaw is similar to that found in all the muscles. Grenet and Vogt report a case of tetanus appearing on the twelfth day after birth, with recovery following twelve daily injections of 20 c.c. of antitetanic serum intramuscularly and subcutaneously. Prevention of tetanus has been brought about through the use of aseptic methods and application of antiseptics to the cord stump. In some localities where there is a large death rate from tetanus, immunization of the mother with tetanus antitoxin before birth has afforded ample protection to the infant (Roux).

Congenital Malaria.—A few more cases of congenital malaria have found their way into the literature (Laffont and Rapoport). Ljachowetsky is of the opinion that a direct transfer of malaria from the mother to child occurs through the placenta. This may not occur in every instance, and it is possible that pathologic changes in the placenta are necessary to facilitate this transmission. Rapoport is of the latter opinion. In those localities in which malaria is prevalent an active campaign against malaria in pregnant malarial carriers is necessary in order to prevent the birth of infants who in turn may become malaria carriers.

Kala-azar.—Cooke reports a case of congenital kala-azar in an infant who was isolated immediately after birth. The Leishman-Donovan bodies were obtained from the spleen by splenic puncture. The author believes that in this case the disease was conveyed through the placenta. Panagotatou reports a similar case.

Typhoid.—Typhoid fever is uncommon in the newborn. In 1902, Griffith and Ostheimer were able to collect reports of twenty-three instances of congenital typhoid fever. Weech and Chen have recently reported a case in an infant twenty-one days old. The infant's serum failed to show agglutinins. Blood, stool and urine cultures were positive. The probable reason for the infrequency of case reports in young infants years ago was the difficulty of diagnosis, while today the disease is so much less common that few cases would occur. The symptoms are variable and certain phenomena such as rose spots and an enlarged spleen are frequently absent. The prognosis is usually considered grave. The case of Weech and Chen was mild and recovery was prompt.

SYPHILIS

It is impossible to determine definitely the incidence of hereditary syphilis because of the fact that many of the studies relative to the frequency have dealt with selected groups of infants. Race plays a very definite rôle in the incidence of syphilis, as does the social and economic condition. Probably the estimates made some time ago by Findlay are still reasonably correct. He concluded that the incidence of syphilis in children is less than 1 per cent. It is still generally conceded that transmission to the second generation occurs by way of the mother, and there is no recent study which has tended to show that infection could be directly transmitted from the father to the child. The fact that few mothers of syphilitic infants give a history or show symptoms of the infection simply indicates that pregnancy markedly ameliorates the usual course and behavior of the disease. As far as transmission to the third generation is concerned, it is indeed difficult to prove, since the presence of a superimposed acquired infection cannot be definitely ruled out.

Pathology.—The pathology of the disease has been well described over the course of many years, and there are only a few findings which have been somewhat overlooked. The auditory apparatus is involved much more frequently than ordinarily supposed, and is usually associated with parenchymatous keratitis. Keidel and Kemp find such involvement in 10 per cent of all their patients. Campas studying the histopathology of the kidney in a group of syphilitic infants and fetuses found the lesions to be more uniform and characteristic in this organ than in any other part of the body, and the spirochetes easily demonstrable in its tissues. In hereditary syphilis there is a retardation of the development of the tubules and an apparent parenchymatous nephritis is present.

Friedenwald made a similar examination of the eyes of syphilitic stillborn. He found that the ocular changes could be classified in the following way: (1) a circumscribed chorioretinitis with chalky white scars; (2) a salt and pepper fundus; (3)a retinal scarring with atresia of the retinal blood vessels, and optic atrophy, and (4) a retinitis pigmentosa, under which group are listed many cases of widely divergent pathogenesis.

Diagnosis.—The Wassermann reaction may not be of definite diagnostic value in the early weeks of life but, according to Cooke and Jeans, a syphilitic infant will manifest a positive reaction by two months of age, and if the reaction is negative at this age, or later, it will remain negative and syphilis may be excluded. This is merely another manifestation of faulty immunological reaction during the newborn period. A child with a strongly positive complement fixation reaction for tuberculosis may manifest a weakly positive reaction for syphilis. The Kahn test agrees fairly closely with the Wassermann test. Weiss has found that examination of the conjunctival and nasal secretions for spirochetes is of great value in the diagnosis of syphilis. Similarly Bulovic has been able to isolate spirochetes from the scrapings of the umbilical cord at a point near the infant.

Treatment.—The prophylactic treatment of syphilis during pregnancy as a rule is very successful, and in the average case surprisingly little treatment is sufficient. However, while in a majority of cases the offspring will be free from the disease, subsequent energetic treatment is necessary to cure syphilis in the mother. Several new antisyphilitic remedies have come into use, notably, sulpharsphenamin and bismuth. The former may be given intramuscularly with little inconvenience, and is particularly useful in the infant. The intraperitoneal use is also safe.

Sanford and Grulee and their associates have found that the intraperitoneal injection of neo-arsphenamin is a rational method in the treatment of congenital syphilis, especially when rapidity of action is required. It is not without danger if faulty technic is used.

There are several valuable bismuth preparations on the market. Bismuth seems to be of value, especially in those sensitive to arsphenamin or mercury and in those who are "arsenic fast." The use of sodium thiosulphate in the instances of poisoning has proved of definite value. Myers and his associates have even found that the simultaneous administration of arsphenamin and thiosulphate is followed by unimpaired therapeutic action of the antisyphilitic drug.

TUBERCULOSIS

The rarity of tuberculosis in the newborn is still notable, probably because of the fact that pregnancy in the advanced stage of tuberculosis is uncommon and if it does occur abortion is more frequent than the delivery of a viable baby. Most of the instances of tuberculosis in early infancy are the result of infection acquired shortly after birth. Morley and Barvoza both report cases of miliary tuberculosis in infants dying a few weeks after birth. In both instances the disease was thought to be congenital. Choremis reports a case of congenital tuberculosis in twins. This author believes that congenital tuberculosis should occupy a more conspicuous place than it has in the past, and is of the opinion that about 5 per cent of all tuberculous infants have congenital tuberculosis.

Prophylactic Vaccination.—Much interest is manifest in the work of Calmette, Guérin and others, in the development of the Bacillus Calmette-Guérin (B.C.G.), which is a strain of bovine tubercle bacillus which, through certain cultural developments, has lost its tubercle producing powers and virulency. By introduction of this organism into animals it is possible to establish immunity in the animals so innoculated. This has been termed "premunity." These investigators have adapted this procedure to premunize newborn infants in danger of exposure to tuberculosis. They state that this vaccination safeguards at least 93 per cent of infants who unprotected would succumb to tuberculosis in the first year of life. In those cases in which failure occurs they believe that an antenatal infection probably exists. In France alone over 5000 infants have been successfully vaccinated in this way, with a mortality of less than 2 per cent. In the non-protected infants of tuberculous environments the mortality rate was 25 per cent during the first year. They recommend vaccination during the first six days in those infants who will probably be exposed to tuberculosis in the first few years of life. According to Weill-Halle and his associates, B.C.G. has incontestable value for immunization and is effective when given orally in the first few days of life. Three doses of 1 centigram each are given during the first ten days of life with revaccination by ingestion at one and three years of age. Subcutaneous vaccination consists of one dose of from 0.01 to 0.02 milligram. Vaccinated subjects should be isolated temporarily to avoid infection during the period in which they are being immunized.

While the French have been very enthusiastic regarding the use of this prophylactic method, others have been less so. Nobel found B.C.G. sufficiently virulent to kill inoculated guinea-pigs, and advises against the general use of this bacillus. Calmette [1] still maintains that B.C.G. is innocuous and believes that there must have been some error in Nobel's experiments. Kraus has studied the pathogenicity and concludes that it is non-pathogenic. He believes, however, that further autopsies on vaccinated infants who have died from intercurrent disease are advisable before judging the product safe for general clinical use. He thinks that B.C.G. possesses some slight virulency which accounts for its ability to immunize. Beck's studies corroborate these views. Recently, Calmette [2] states that 96,000 children have been vaccinated in France, and 45,000 in French Indo-China, and he claims that it is inoffensive and efficacious. Ribeiro reports a case of an infant dying of tuberculous meningitis which had received the prophylactic vaccination.

So far, very little has been done with B.C.G. in America. However, the results which are being obtained in Europe are such that more interest in this subject should be manifest in this country. The method according to the reports carries with it very little danger, and certainly is of sufficient efficacy to warrant its use at least in those infants born of tuberculous mothers or those who must be subjected to a tuberculous environment after birth.

THE RESPIRATORY SYSTEM

Congenital Stridor.—There have been a few reports of cases of congenital stridor in the last few years, the most common of which have been those due to cysts at the base of the tongue. Such cysts are not as uncommon as one would ordinarily suppose, and the diagnosis is made by careful digital examination of the throat. The treatment is extirpation of the tumor but it is wise to assure oneself that the thyroid gland is present in its usual place before such a tumor is removed (Post, Thomas, and Bagg). Bagg reports seven cases of congenital stridor in which one was due to thymic hyperplasia, two due to malformation of the epiglottis, two due to malformation of the lower jaw, one with macroglossia, and one from a congenital goitre. Meyers mentions a rather unusual form of stridor due to pressure upon the trachea by a misplaced pulmonary artery.

BRONCHI AND LUNGS

Malformations.—Malformations of the lungs are extremely rare. Vanheisser adds to the literature a case of congenital absence of one lung. The presence of a double bronchial tree in the single lung of this patient indicates that the original single pulmonary anlage failed to undergo division.

Injuries and Hemorrhages.—Two cases of rupture of the lung have been reported. Kaiser and Schrader cite a case in which the forced breathing of the asphyxiated newborn infant resulted in rupture of the lung tissue with escape of air into the anterior and posterior mediastinum, pericardial sac and left auricle and ventricle. In this case artificial respiration was not given. The case of Flipse was one in which the inspiratory efforts of birth were sufficient to rupture an alveolus with the development of a pneumothorax.

Gross and microscopic hemorrhages in the lungs are not uncommon in infants dying during or shortly after birth, and are nearly always found in premature infants, probably due to the greater ease with which the lungs may be torn during delivery, and the lesser ability to resist external violence. Subpleural ecchymoses are commonly associated with hemorrhages of the lungs (Walcher).

Pneumonia Neonatorum.—From time to time there have appeared a few reports of cases of pneumonia in newborn and stillborn infants, especially those showing a severe infection. Few extended studies have been made of the lungs of newborn babies dying in the first few days of life, or of stillborn babies. Thaysen found pneumonia in 8 per cent of his first series of cases, but when he began to pay particular attention to the subject he found pneumonia in 42 per cent. Pneumonia may occur in several ways: (1) placental transmission; (2) aspiration of secretions or exudates of the birth canal, or aspiration of food or secretions from the nose or mouth after birth; (3) aërogenous infection; (4) metastatic pneumonia from infection of the umbilicus or of the intestine. Johnson and Meyer found that 19 per cent of 500 stillborn and newborn infants showed evidence of pneumonia. Congenital pneumonia of antenatal origin is frequent, due usually to aspiration of infected amniotic fluid following infection of the amniotic sac after premature rupture of the membrane. In death from postnatal pneumonia, which occurs most frequently in premature infants, aspirated food is the usual cause. The pathologic characteristics of congenital pneumonia are somewhat different from postnatal infections. It is nearly impossible to recognize the presence of pneumonia from the gross appearance of the lungs, the most common changes being slight enlargement of the organ with a reddish, moist appearance upon section, suggestive either of edema or congestion rather than pneumonia. Pleuritis is rare. Microscopically the inflammation is of wide extent, involving practically all of the alveoli. The exudate consists of a small number of polymorphonuclear leukocytes, with a few mononuclear cells and red cells, and a very small amount of fibrin. The fact that bacteriologic study of these lesions is so unsatisfactory has led to the suspicion that some of the cases might be due to chemical irritation from aspiration of amniotic fluid mixed with antiseptics. Hintner, studying the changes in the lungs secondary to the aspiration of amniotic fluid, found no consistency of pathologic changes, but frequently noted definite inflammatory changes, often of a suppurative nature.

Lauche reviews nine cases of lobar pneumonia in newborn infants, in all of which the mother had lobar pneumonia. The infants died before the third day. Gordon and Lederer report a case of intra-uterine lobar pneumonia which died on the third day. Autopsy revealed an extensive lobar pneumonia with pleurisy, empyema, and a generalized sepsis, and culture of the pus from the chest showed a type of pneumococcus similar to that obtained from the mother's blood culture two days before delivery. O'Connor describes a pneumonia with pleurisy and effusion in an infant which died at day after birth. Bacteriologic studies showed hemolytic streptococci. The distribution of the infection in the lungs pointed to a hematogenic rather than a bronchiogenic origin. The mother had had a severe sinus infection during the latter months of pregnancy.

The results of these interesting reports lead us to assume that many newborn infants die from an unrecognized lung infection. This would probably explain many of the sudden and unaccountable deaths a few days after delivery. Symptoms are frequently lacking. It is apparent that before due recognition is given this disease as a causative factor in infant mortality, more detailed examinations of the lungs must be made, and especially are microscopic studies necessary.

Tumors of the Bronchi and Lungs.—De Lange reports a case of multiple cysts of the lung which were connected with the bronchi. Considerable interstitial emphysema and pneumonic consolidation were found. This patient survived two months in all, and death was due to a terminal pneumonia. Swanson and Platou state that there are about 112 available reports of congenital cysts of the lung, and describe such a case in which a single congenital cyst of bronchiogenic origin was found in the right lung. This cystic condition should more properly be classified as a case of congenital bronchiectasis.

The Pleura.—Stewart and Linner report a case of chylothorax in an infant of four days, which is the youngest on record. The chylous fluid aspirated from the chest following the diagnosis of hydrothorax apparently came from a rupture in the thoracic duct. As has been previously mentioned, subpleural ecchymoses are not uncommon, especially in asphyxial conditions. Ross describes a case in which on the fifth day the infant became pale and the respirations very rapid and shallow. Fluid could be demonstrated in the right lung, and upon necropsy this cavity was found filled with fluid and clotted blood and the lung greatly compressed and collapsed. Flipse reports a case of pneumothorax due to rupture of an alveolus during the inspiratory efforts at birth. Fabris reports a case of purulent pleurisy which terminated in death on the fifth day. A frank empyema was found on the left side, from which a long chain streptococcus was isolated.

CARDIOVASCULAR SYSTEM

Roentgenological Studies.—Weymuller and his associates, in a daily study of the cardiac shadows of newborn infants, confirmed the findings of previous observers that it was impossible to measure accurately the size of the heart, and the great individual variations in size and contour made classification and description useless. There was a thoroughly regular tendency towards decrease in size of the shadow after the second day.

Congenital Heart Disease.—There have been innumerable reports of cases of congenital heart disease in the last few years, so many, that a review of them would be too exhausting. Reuss brings up an interesting subject in the disappearance and reappearance of heart murmurs in the newborn. Many of the demonstrable loud systolic murmurs heard in the first few days may disappear later. These are apparently the result of continued patency of the fetal passages. In other instances a systolic murmur may develop only after several days, as in a case of transposition of the great vessels with septal defects. Few studies have been made of the reactions of the congenital cardiac patient to the normal strain of health or the extra strain of disease. In a study of 100 cases Irvine-Jones found two prominent features, cyanosis and nutritional difficulties—the latter is usually associated with cyanosis. Dyspnea is next common. Subnormal mentality was present in a little over one-fourth of the patients, seven of which were mongoloid. In the handling of such patients high caloric diets are of value, and exercise is not advisable until the child has gained weight. Prevention of cold and exposure are very important, and all diseased foci of infection should be removed if possible. When great disability is present private tutoring is necessary. Digitalis is of no value in such cases. Rosler points out that frequently Roentgen ray examination of cases of congenital heart disease give entirely negative findings, which was the case in more than 16 per cent of his series. He finds that alcoholism and consanguinity are important factors in the etiology of this disease, whereas syphilis is not.

Piper and Irvine-Jones draw attention to a condition called arachnodactylia, which is associated with congenital heart disease. It is characterized by unusual length and slenderness of the extremities. The accompaniment of congenital anomalies such as heart defects and webbed fingers, together with many other abnormalities, differentiates it from gigantism. Some consider this an instance of partial gigantism due to early intra-uterine endocrine exhaustion.

Ectopia Cordis Pectoralis.—This condition apparently is much more common than ordinarily supposed from the reports appearing from time to time. Pruska and Saidl have collected some twenty-five cases besides one of their own, and Jedlicka, Prusik and Weber, and Wedd have added others. At the present time a moving picture film of such a case in action may be rented from one of the commercial houses for demonstration purposes.

Idiopathic Congenital Hypertrophy.—This condition is relatively uncommon, only seventeen authentic cases being on record. The cause of this abnormality is not definitely known. In the case reported by Stoloff microscopic studies of the myocardium revealed lymphocytic infiltrations and mild cardial degeneration, which were sufficiently generalized to explain the enormous enlargement of the heart. In this case the weight of the heart was 155 grams. Transient enlargement may occasionally occur as described by Weymuller, in which roentgenograms in the first two days of life showed an enormously dilated heart which occupied almost the entire thoracic cavity without signs of cyanosis or cardiac murmurs. Later this shadow had assumed normal proportions.

Congenital Atresia of the Foramen Ovale.—Patent foramen ovale is an extremely common finding, but intra-uterine occlusion of the foramen ovale is a rare and distinctly pathologic condition. Lehman reviews five cases and reports one of his own. The infants either manifest a marked edema or cyanosis at birth, or as in one atypical case described there was a major cardiac anomaly which modified the symptoms. When the foramen closes before birth all the venous blood goes to the right side of the heart. The result is an overload on this side with decompensation and edema, dilatation and hypertrophy. After birth there is a relatively small output of oxygenated blood by the left side of the heart and anoxemia of fatal severity results.

Hematomas of the Heart Valves.—This condition has been more frequently noted in the last few years since our attention has been called to it by several observers. We have seen it frequently at autopsy. The term seems to be a misnomer, since the lesions are not true hematomas. They are too frequently erroneously considered manifestations of that doubtful but often mentioned disease, fetal endocarditis.

Congenital Heart Block.—Since the review of Eyster and Middleton in 1920, Yater has been able to collect a total of thirty cases of congenital heart block, including one of his own. Of these thirty, only three have come to necropsy, and in only two were histologic studies made. Either prenatal endomyocarditis or a developmental defect in the auriculoventricular bundle theoretically may cause the condition, but in the cases so far studied only the latter have been found. Recently, Leech, Nicolson, Schulman and Green, and McIntosh have reported similar instances.

Congenital Transposition of the Cardiac Vessels.—This condition is comparatively rare, only ninety-seven cases having been reported up to 1930. The term describes the anomaly accurately and should not be confused with dextrocardia, for in the condition of which we are speaking there is a normal arrangement of the heart chambers with or without septal defects. It results in persistent cyanosis beginning shortly after birth with a peculiar lack of physical signs in the uncomplicated cases. The "morbus cæruleus" of the older writers is for the most part a manifestation of this abnormality. It is often associated with other cardiac anomalies, especially a patent interventricular septum. The prognosis is grave, death resulting within the first year in most cases. Occasionally, because of other anomalies which tend to correct the deficient aeration of the blood, this condition is prolonged to the adult life (Kato).

Pericardium.—Congenital absence of the pericardium is extremely rare. Moore has reviewed 64 cases. In only one case was it right sided. These defects are sometimes associated with anomalies elsewhere. In most instances there were adhesions between the heart, pleura, diaphragm, and thoracic wall. Poeck reports a case of pneumopericardium in an infant dying shortly after birth. There was an associated pulmonary emphysema which would explain the presence of air in the pericardial sac.

THE BLOOD

Many of the cases of purpura hæmorrhagica reported in the past years have been probably instances of sepsis neonatorum. Liebling reports a case of congenital essential thrombocytopenia in which the mother also manifested symptoms of purpura during the last few months of pregnancy. The infant showed petechiæ on the face, trunk, and extremities, and the platelet count was 210,000. Both the infant and the mother recovered. The case reported by Rushmore was very similar. In Waltner's case the mother had had signs and symptoms of purpura for several years. Greenwald and Sherman observed a case of essential thrombocytopenia in an infant who died on the fourteenth day. There were 30,000 platelets present, this reduction in the number of platelets being attributed to an insufficiency of megakaryocytes of the bone marrow. At autopsy there was no evidence that this disease was acquired after birth. The presence of anomalies of the heart and of the thymus gland with the defective bone marrow supports the idea that the disease was congenital.

Severe anemia in the newborn has been uncommon as far as the records of case reports are concerned. Since a few cases have been described in the last few years more notice is being taken of pallor in the newborn (Sanford). So far, six cases have appeared in the literature (Ehrmann), with one death, all of which have been characterized by pallor, reduction in the erythrocytes, and hemoglobin content, with normal morphology of the leukocytes. Since this report Gelston and Sappington have reported a case and Foote mentions five others. One of us has seen two others, one already mentioned under icterus (Buhrman), and another rapidly fatal case developing on the ninth day, death on the tenth, the autopsy showing no other cause of death. The red cells occasionally showed achromia, polychromatophilia, anisocytosis, and poikilocytosis. In one instance the red cell count was below 1,000,000. In most of the cases the spleen has been enlarged and jaundice was present (Bonar). We have reported a case in which neither were present. Another case has recently come under observation in which the infant was severely jaundiced. As this disappeared the anemia became more pronounced, until at the time of death the hemoglobin was 18 per cent and the red cell count was 960,000.

So far no explanation has been offered, but it is not unlikely that it is merely a manifestation of an excessive hemolysis during the period when hemolysis normally occurs. Our last case would seem to suggest this theory.

Priesel and Winkelbauer report a case of Hodgkin's disease appearing in a woman a short time before delivery. The child developed a nodular swelling in the left supra-orbital region at eleven weeks, and died at the age of four and one-half months. Histopathologic changes characteristic of Hodgkin's disease were found at necropsy. The authors believe this an instance of placental transmission of the disease.

The occurrence of lymphatic leukemia in five children in one family, and in the last four of eight children in another family, has been mentioned by Macciotta. The fact that we have seen acute lymphatic leukemia develop in unrelated playmates within a week of one another would suggest, as might these cases, a possible infectious etiology for the disease.

THE SPLEEN

In the last few years a small group of cases which were erroneously considered as Gaucher's disease up to this time have become established as a distinct clinical and pathologic entity, variously called Niemann-Pick's disease, lipoid cell, splenohepatomegaly, and lipoid histiocytosis. This condition occurs chiefly in Jews, and is characterized by slowly progressing emaciation, enlargement of the spleen and liver, and death before the age of two years from malnutrition or intercurrent infection. There is considerable physical and mental retardation, and at times some of the symptoms of mongolism or amaurotic family idiocy are present. There is slight enlargement of the lymph-nodes, a brownish pigmentation of the skin, and a slight progressive anemia with moderate leukocytosis. The spleen is large, firm, and upon cut section is homogeneous, with a mottling of yellow or gray patches (Niemann, Pick, Bloom, Baty, and others). Histologically the outstanding feature is the presence of large vacuolated foam cells in the spleen, liver, lymph-nodes and bone marrow. So far no cases in the newborn have been reported.

DIGESTIVE SYSTEM

Congenital Anomalies of the Tongue.—There have been a few cases reported in the last few years of congenital cysts of the tongue which have been of sufficient size to cause stridor. Treatment consists of extirpation (Post and Thomas). Bagg reports one case of macroglossia of sufficient magnitude to cause stridor. Courtin mentions the case of a newborn infant who suffered from repeated attacks of asphyxia. The cause was finally traced to an imperfectly developed frenum of the tongue.

Congenital Atresia of the Esophagus.—This subject has been so thoroughly covered over the period of many years that little can be added to it. Innumerable cases have been reported in the last five years, most of which are associated with tracheo-esophageal fistulas. For any one desiring to review the literature, the reports of Simpson, Beatty and Sheldon may be consulted. Occasionally the esophageal stenosis is associated with stenoses in other parts of the alimentary tract, such as the small intestine, or anus. Krokiewicz found pyloric stenosis associated with an esophageal stenosis in one case. Noltman reports a rather unusual instance of atresia of the esophagus, associated with congenital varicosities of the esophageal mucosa. Bleeding from these varicosities at first lead to the erroneous idea that this was a case of melena neonatorum.

Congenital Pyloric Stenosis.—Little has been added to the subject of pyloric stenosis in the last few years. Caulfield mentions the familial incidence of this condition, a fact which so far has received little attention. Occurrence of this in two members of a family has been relatively frequent, and a few instances have been reported in three members of one family. Finkelstein mentions a family in which four had the disease. The occurrence of pyloric stenosis in twins has been noted in three cases. In all, about twenty cases have been reported in which there is a record of other members of the family being afflicted.

Foote calls attention to the fact that the earliest report of congenital pyloric stenosis is the case mentioned by Armstrong, in 1771. MacHaffie reports a case of true pyloric stenosis in which the diagnosis was made and the operation performed thirty-four hours after birth. Symptoms in his case appeared within fifteen minutes after birth. The infant recovered.

The Small Intestine and Colon.—Atresia and stenosis of the small intestine, colon and anus continues to be a very common congenital anomaly. The reports are so many that no attempt to review them will be made. For recent reviews, the articles of Hahn, Heckel and Apfelbach, and DeSanctis and Craig may be consulted.

Congenital Microcolon.—Greig thinks this condition may be more frequent than ordinarily supposed. The symptoms are persistent vomiting from birth, obstipation, rapid emaciation, with the presence of masses palpable through the abdominal wall, and abdominal distention. The colon is firm and small, with a definite lumen. The different layers of the wall are proportionately normal, and cases examined have shown the presence of intestinal secretions but no meconium. He concludes that this condition is not an anatomic defect but a physiologic aberration. The only hope for cure is anastomosis.

Diverticulum of the Intestine.—While diverticulosis is not uncommon in adults, few cases other than Meckel's diverticulum are found in the newborn. Recent reports of cases of Meckel's diverticulum emphasize the fact that bleeding is not an uncommon symptom (Seeger and Tisdall). The presence of gastric mucosa in this diverticulum is frequent, and as a result of such an heterotopia, peptic ulcers are not infrequent. So far no such instance of ulceration with hemorrhage has been reported in the newly born infant. Hunter reports the rare instance of perforation of a Meckel's diverticulum in a newborn infant. Only one other such case has been recorded, although volvulus of a Meckel's diverticulum in a two day old infant has been described.

Epithelial Heterotopia.—Epithelial heterotopia of congenital origin is relatively frequent in the alimentary tract and is limited, almost without exception, to portions of the intestine above the ileocecal valve. As a rule, there is little clinical significance to these aberrations, except in the following instances: (a) heterotopias of the gastric mucosa in the small intestine and in Meckel's diverticulum, which may be the seat of ulceration, hemorrhage, and perforation; (b) heterotopias of the stomach and small intestine, which give symptoms later on in life simulating ulcer or cancer; (c) nodules of aberrant pancreas in Meckel's diverticulum with the production of mechanical obstruction of the intestine; (d) certain umbilical polyps which may cause discomfort or pain and an irritating discharge (Taylor).

Ventral Hernia.—Congenital defects or absence of the musculature of the abdominal wall are uncommon. Ikeda and Stoesser have collected fifteen such cases from the literature, and report one of their own. In practically all of these cases abnormalities of the genito-urinary system have been found at necropsy. The fact that such anomalies are present has led to the assumption that the defect of the abdominal wall is due to pressure by the distended bladder. Congenital hernia of the linea alba is much more common. Charlton has been able to find reports of 250 such cases.

Diaphragmatic Hernia.—This condition has received considerable attention in the last two decades, probably because of the routine employment of roentgenologic examinations. A recent review of the literature has been made by Greenwald and Steiner. Patterson reports a case of bilateral diaphragmatic hernia. This case is interesting because of the rarity of bilateral involvement. There has been considerable controversy regarding the possibility of birth injuries causing eventration of the diaphragm due to paralysis of the phrenic nerve. Some observers think that it is impossible to cause sufficient damage to the phrenic nerve during breech extraction for phrenic paralysis to occur. Certainly, from the case reports at hand, eventration of the diaphragm, when present, frequently follows breech deliveries. In a case seen by us there was a history of a very difficult delivery of the aftercoming head. Friedman and Chamberlain are of the opinion that phrenic nerve paralysis is probably not a rare type of birth injury, and in their case of eventration of the diaphragm the child also had paralysis of the right arm due to injury at delivery. Landsberger reports a similar case. Dyson reports paralysis of the right diaphragm following accidental puncture of the neck in the region of the phrenic nerve by scissors at the time of birth.

Cardiospasm.—Cardiospasm in the newborn infant is extremely rare, and hitherto has escaped early diagnosis. Segar and Stoeffler and Jackson have reported three instances of this condition, which together with three cases recently described by Birnberg brings the total number of reported cases up to six. The outstanding symptoms are forcible vomiting during or soon after nursing, beginning with the first feeding, and the vomitus contains no gastric contents. Rapid loss of weight and dehydration fever are the usual consequence. Roentgenological examination is simple and diagnostic, showing little or no opaque material in the stomach, and a dilatation of the esophagus above the cardiac orifice. This condition is frequently associated with a mild pylorospasm. Treatment consists of overcoming the spasm by passing a catheter through it for a number of feedings. This condition is probably much more common than ordinarily supposed.

Hemorrhage.—Little has been added to the subject of gastro-intestinal hemorrhage in the newborn infant in the last few years. The condition still is relatively frequent in spite of the fact that studies of the bleeding and coagulation times during this period have shown that they are retarded and that early administration of blood or serum to the newborn infant will hasten them. The prophylactic administration of blood and serum, although recommended in those cases in which the bleeding and coagulation time are retarded, has not come into common usage. A few cases of esophageal bleeding as a cause of melena neonatorum has been reported. Noltman reports melena in a child which was found to have atresia of the esophagus with varicosities of the esophageal mucosa. The cause of the blood in the stools was due to the latter finding. Diamantopoulos found that an ulcer of the esophagus was the source of bleeding in a case of melena. A similar case has been described by Steinert.

Hergt found gas bacilli in unusual profusion in two cases of melena neonatorum. In these cases he is inclined to ascribe pathogenic properties to the gas bacilli on account of their great numbers. This is interesting in view of the fact that occult hemorrhage is relatively common in the newly born infant. It has been thought that occult bleeding is due to the initial irritation set up by the invasion of bacteria into the intestines shortly after birth. The determination of the frequency of the presence of gas bacillus in the stools in relation to occult bleeding would be valuable in settling this question.

Injuries.—A few cases of rupture of the intestine have been reported. In the case of Skiles the rupture was due to a volvulus of the small intestine, *in utero,* which resulted in perforation. Russell reports the spontaneous rupture of the cecum in the newborn. Twenty-two such cases have been reported, in five of which the rupture occurred during intra-uterine life, in fourteen during birth, and in four during or after birth as a complication of imperforate anus of rectum (Wing).

The Liver.—Congenital malformations of the liver itself are uncommon, but anomalies of the gall-bladder and bile ducts occur with sufficient frequency to be more than a pathologic curiosity. The symptomatology and pathology of these conditions is well described, but there is conflicting data regarding the ability of these infants to digest fat. Wallgren is of the opinion from metabolic studies in such a case that it is not the lack of bile in the intestine that causes the death of these infants, but rather the harmful effect of cholemia on the organism as a whole that results in their death by influencing the nutrition and digestion indirectly rather than directly. Ladd has offered us a little hope in the prognosis of congenital atresia of the bile ducts in his report of a series of eight cases, in which a successful operation was performed in six. He states that surgical treatment may be successful if either the gall-bladder or the common duct has a patent connection with the liver. The time at which operation should be resorted to is when the diagnosis seems reasonably certain, and after wasting or intercurrent infection has set in. In view of this report, it is evident that exploration should be done in these cases much more frequently than it has in the past.

THE NERVOUS SYSTEM

Malformations.—A hitherto undifferentiated congenital craniofacial deformity has been described by Greig, for which he coined the term "hypertelorism." The outstanding feature of this condition is the great breadth between the eyes due to interference in development of the basal skull bones. As a result of cranial deformity somewhat similar to oxycephaly occurs. It is not unlikely that some of the cases of this latter condition are more properly instances of hypertelorism. The condition is associated with evidences of cerebral involvement such as paralyses and atrophies of some of the extremities and deficient mentality. Greig reports two such cases, and Muir another. Personally we have been interested in a child showing many of the characteristics of this condition, but, unfortunately, the patient was lost sight of before a careful study of it could be made. The interpupillary distance was abnormally great, the skull was somewhat tower-like and there was partial paralysis and muscular atrophy of the arms, hands, legs and feet. The child's mentality was moderately subnormal.

Oval defects in the flat bones of the head are uncommon, and have been given the term "luckenschadel" by some. Others use the term "congenital lacunae." Weill-Halle and Weill report two such cases involving the parietal and frontal bones. A few years ago we observed a single defect 0.5 centimeter in diameter in the right parietal bone through which the meninges bulged. This defect gradually filled in so that by the age of one year no evidence of it could be found.

Obstetric Paralysis.—This type of birth injury has been the subject of much study, but, even so, little change in the views concerning this condition has occurred in the past few years. Regarding injuries to the brachial plexus, a few cases are on record in which there has been an associated injury to the phrenic nerve, with resulting paralysis of the diaphragm (Friedman and Chamberlain). Landsberger and Dyson observed a paralysis of the right diaphragm following an accidental puncture wound of the neck in the region of the phrenic nerve. Other cases of diaphragmatic paralysis unassociated with brachial palsy have been reported.

Congenital Facial Paralysis.—The traumatic form of this condition is the result of forceps trauma, or antepartum or intrapartum compression. Those due to forceps trauma are usually unilateral and peripheral. Occasional bilateral cases have been observed, and central paralyses are known. The prognosis is generally good. Cases due to antepartum compression of the head of the fetus against its own shoulder or against maternal bony prominences manifest along with unilateral peripheral facial paralysis, certain pressure defects of the ear, face, jaw and shoulder. These defects consist of a depression of the side of the face involved and are sometimes confused with the so-called stigmata of degeneration. The prognosis in these cases is unfavorable as far as recovery is concerned. Those due to intrapartum compression show unilateral peripheral facial paralysis together with evidence of injury in the region of the nerve, such as edema, extravasations of blood, and depressions in the skull. The prognosis of this group is usually good. For a more complete consideration of this subject, the review of Bonar and Owens may be consulted.

Intracranial Hemorrhage.—This subject has been the center of such interest recently that an attempt to review the literature would be too exhausting and confusing. As far as any great increase in knowledge concerning this condition, it must be acknowledged that little has resulted as a consequence of this remarkable interest. We know that intracranial hemorrhage is one of the most common causes of mortality and morbidity in the newborn, and that the only treatment of any particular value is prophylactic. The prevention of such injury is most important and must come through the practice of better obstetrics. Proper prenatal care as well as proper care during delivery is most important, and it is not until the obstetrician and general practitioner develop this field of preventive medicine that reduction in the incidence of intracranial hemorrhage will occur. Prevention of toxemias of pregnancy and general improvement of the health of the pregnant woman will result in a decrease in the number of premature births, and since this intracranial complication is more common in the premature infant its incidence can be reduced in this way. As far as the active treatment of this condition is concerned, there have been no new methods of any value advocated. While careful prenatal care is probably the largest factor in the incidence, more specialized care during delivery will reduce the number of cases. So important is this that Neumann and Levy feel that 75 per cent of these injuries can be eliminated in expert hands by prohibiting the use of high forceps or forceps to the aftercoming head in breech deliveries, manifestation of a habit of noninterference except under definite indication, with more judicious use of pituitary extract, and more care and gentleness in resuscitation.

Some still advocate the surgical treatment of intracranial hemorrhage if repeated lumbar punctures and drainage do not influence the symptoms. Cisternal puncture is thought by some to be harmless and more efficacious. Sharpe recommends intracranial surgery in those cases which do not respond to drainage by lumbar puncture and blood injection. In the hands of some this may be a very valuable procedure but, except in expert hands, such a measure certainly would result only in an increase in the mortality rate. In our opinion, rest constitutes the chief part of the treatment aside from blood injections. The infant should not be disturbed for bathing, and should not be put to the breast for one or two weeks. The removal of fluid by lumbar or cistern puncture may be of importance in reducing the intracranial pressure, but frequently when this pressure is reduced further bleeding occurs. In the first day or two of life it is wise to refrain from spinal drainage until the possibility of recurrent hemorrhage is obviated by use of blood or serum. Dollinger in his monograph on birth injuries to the nervous system considers this subject at length, and any one interested in intracranial hemorrhage should not fail to consult this author.

Meningitis.—Meningitis in the newborn is uncommon, but it is not unlikely that many cases of this disease escape notice and that certain cases are erroneously diagnosed intracranial hemorrhage. In some instances of intracranial hemorrhage, meningeal inflammation is associated, both soon and long after injury, due no doubt to a decreased resistance of this membrane. Most of the cases of purulent meningitis have to do with other than the meningococcic variety. In view of the fact that we are experiencing an increase in the prevalence of the epidemic variety of meningitis, it is not unlikely that the next few years will see an increase in the incidence of this type of the disease. Nachtnebel reports five cases of meningitis in the newborn, all of which were of the pneumonococcic variety. There was hardly any exudate, and the diagnosis could be made only through the bacteriological and histologic examination. The probable portal of infection was the pharynx.

Karplus observed three fatal cases of meningitis in newborn infants, two of which were due to the staphylococcus, which had reached the meninges by way of an infected spina bifida. The other case was one of meningococcus infection. In her review of thirty-seven cases she finds that 30 per cent are due to *B. coli,* and 32 per cent to staphylococcus and streptococcus infections, while in 10 per cent the pneumococcus and meningococcus were responsible. As has been mentioned before, it was noticed that the ordinary symptoms of meningitis were often lacking.

Encephalitis.—Berkholtz has reported seven more cases of congenital interstitial encephalitis. The cases occurred in families, in each of which three children were lost immediately after birth. Premature infants were especially susceptible. In view of the familial tendency the author believes that the disease is a separate clinical entity rather than the result of injuries or asphyxia as has been claimed by some. Hassin reports a case of a newborn infant dying of acute encephalitis which was diagnosed at autopsy. Moncrief describes a similar case in which microscopic examination of the brain revealed a typical encephalitis lethargica.

Cerebral Birth Paralysis.—While there may be some question as to the cause of this condition, certainly intracranial hemorrhage is one of the most important factors. Recently there has been considerable talk about the operative treatment of these patients. The most successful treatment is peripheral neurectomy of the nerve supply to the spastic muscles, followed by attempts at restoring the proper balance between the opposed muscle groups by exercise. Children who are of nearly normal mentality without athetosis or marked incoördination of movements other than those due to spasticity, those with a history of some improvement, and those willing and old enough to coöperate in the postoperative exercises are the most favorable ones to operate upon.

Cranial Nerve Palsies.—Many cases of unilateral facial paralysis of nuclear origin have been reported in association with involvement of other nuclei of the cranial nerves. Only seven cases of uncomplicated bilateral facial paralysis of nuclear origin have been reported (Bonar and Owens). Moebius attributed the nuclear defect to atrophy, but at present the term "nuclear agenesis" seems to be the one of choice, since the nuclei of the cells are absent or diminished in number, and those remaining are abnormally small. Little is known about the etiology of this condition, but it may be that this is another instance of abiotrophy or decreased vitality of the cells. In some instances there may be a familial tendency. Infantile familial progressive bulbar palsy (Londe) and infantile pseudobulbar palsy (Oppenheim) are probably merely mild variations of nuclear agenesis. The prognosis as far as life is concerned is good, but little improvement can be expected.

Microcephaly.—The diagnosis of microcephaly rests upon three never varying features: cranial measurements all below normal, frontoparietal recession with occipital flattening, and dwarfism. To these may be added early closure of the fontanels and sutures, recession of the chin and a prominent nose, and a pointed ridged vertex. The majority of microcephalic patients give a history of pronounced neuropathic familial stock. Familial microcephaly is common, from one to seven cases in one family having been recorded. Whitney records four instances of microcephaly in twins.

Amaurotic Family Idiocy.—This condition is found almost always in the Jewish race. Cordes and Horner, however, have recently reported two cases in Japanese families. In both instances there was a history of consanguinity.

Mongolian Idiocy.—This condition is of such frequency that it seems remarkable to us that so few cases are diagnosed at an early age. The great majority can be told at birth and yet this rarely happens. Certainly the characteristics are such that little ingenuity is required to make the diagnosis. The occurrence of this disorder in twins has never been found frequent, especially in both twins. Some six cases have been reported, the latest being that of Mitchell and Downing. Four of these cases are definitely known to have occurred in single ovum twins. Mongolism in one of twins is somewhat more common. In the last few years the number has been increased to about fifteen cases. At present we have such a case under observation. These occur in double ovum twins. Regarding the etiology of this disorder little change in thought has been manifest. The theory of Crookshank is interesting but impossible to prove. He believes it due to reversion to type, subsequent to admixture of Mongolian blood in the ancestors probably during the Tartar invasions of Europe. Occasional cases have been reported in other than the Caucasian race. Brahdy reports an instance of mongolism in a Negro.

THE GENITO-URINARY TRACT

Congenital Abnormalities.—Congenital abnormalities of the urinary tract are much more common than ordinarily supposed, and are the cause of many obscure urinary symptoms. Schippers and De Lange found an incidence of 7 per cent of congenital deformities of the urinary tract in all autopsies. Fortune has been able to collect 419 instances of unilateral agenesia of the kidney, to which he has added three cases. The ureter on the affected side was absent in about half, and the renal vessels absent in one-fourth of the cases. The suprarenal gland was missing in forty-six cases. According to the records, a single existing kidney is more prone to disease than two normal ones. Gilman describes a pelvic kidney of normal size which was composed of three lobes, each with an artery. No symptoms were caused by this abnormality. Kleine presents an example of a diaphragmatic defect through which the left suprarenal gland and the upper pole of the left kidney protruded. Ten such cases of diaphragmatic defect with renal dystopia have been reported. It is very probable that the fetal kidney, which ascends and reaches the diaphragm at or just before its closure, in these cases ascended more rapidly than normal, thus preventing closure. Complete bilateral duplication of the ureters and renal pelves are not common. McKinney and Cary have collected forty cases, of which only nine were discovered by cystoscopy and pyelography.

Pyelitis.—Careful studies of the urinary tract in cases of chronic pyelitis have shown that many of the persistent cases are due to congenital abnormalities of this tract. Helmholz, upon analysis of ninety-four cases, found anomalies of the kidney in eighteen, of the ureter in thirteen, of the urethra in six, and of the bladder in fifty-seven. Campbell notes that about one in fifty of all children have some form of ureteral obstruction. Such reports have been made possible through the manufacture of smaller cystoscopes, which can be used in infancy and childhood. The development of such instruments has led to more careful examinations of urinary disturbances in childhood, and has facilitated the treatment of such conditions. Sauer has reported fifteen cases of neonatal pyelitis. These infants all had symptoms referable to the gastro-intestinal tract or to the central nervous system. *B. coli* was the offender in all cases. The preponderance of these infants were male. In Graham's cases the causative organisms were *B. coli,* non-hemolytic streptococcus, and *Staphylococcus aureus.* The history of onset was on the second or third day, which led to the consideration that the infection was probably of an intra-uterine nature.

Tumors.—A few tumors of the urinary tract have been reported. Brady has collected twenty cases of solid tumors of the urachus. Eighteen of these were malignant, of which seven were sarcomata and eleven carcinomata. Malignant tumors of the kidney are not as rare as ordinarily supposed. Lyman found upon résumé of the literature that nearly all of these tumors were embryonal. Metastases were not uncommon, and were found most frequently in the lungs, renal veins, and liver. He reported a case of embryonal sarcoma in an infant of nine months. Roman reported a case of malignant neuroblastoma in an infant of nine days. The tumor involved the suprarenals and the liver, and its origin was probably in the left suprarenal gland.

THE BONES AND JOINTS

Skull.—The condition "luckenschadel" consists of multiple sharply defined areas of unossified tissue, usually occurring in the parietal bones. Oval defects of this sort have been described from time to time. Weill-Halle and Weill have recently described cases in which the parietal and frontal bones contained these oval defects. A single defect of this nature has been seen by one of us, in which slight bulging of the meninges through this defect could be detected. By the end of one year no evidence of the window could be found. Pressure defects of the face, due to antepartum compression of the head of the fetus against its own shoulder or against maternal bony prominences are sometimes seen associated with defects of the ear due to the same cause. This asymmetry has sometimes led to the erroneous idea that it is one of the stigmata of degeneration. Essen-Möller describes several cases of such asymmetric involvement of the face, ear and jaw.

Oxycephaly has been frequently reported in the last few years. This condition, also called turricephaly, together with scaphocephaly, trigonocephaly, and phagiocephaly can be classed under the term "craniosynostosis," and has its origin in pathologic synostosis of two or more bones of the calvarium. There are often associated deformities of a similar nature. A condition called "hypertelorism" by Grieg might well come under this general classification. It consists of a faciocranial deformity in which the great wings of the sphenoid are abnormally small, and the lesser wings large. As a result the eye sockets are widely separated and the nasal cavities broadened. Frequent paralytic involvement of the extremities occurs in this condition as well as a subnormal mentality. Muir and Wyllie have described similar cases.

The Trunk.—Congenital short neck is relatively uncommon, and is characterized by close-set cervical vertebra with prolonged transverse processes. Another rare condition is that termed Klippel-Feil's syndrome. It consists in the numerical reduction of the cervical vertebræ by fusion. A few cases of this have been recorded, namely, those of Simon, Nobel and Frawley. Frequently, other anomalies are present in this condition. We have observed a case of this syndrome in which there was associated a bilateral congenital elevation of the scapula.

Congenital scoliosis may be divided into two types, that in which there is no osseous anomaly, and that in which there is an osseous anomaly. The latter is much more common and occasionally is due to the presence of an extra wedge-shaped vertebra. Congenital torticollis, which occurs in about 0.5 per cent of cases, is probably more likely to be due to intra-uterine shortening of the sternocleidomastoid muscle as a consequence of pressure than by birth trauma. Von Lackum reports four infants with congenital torticollis who were definitely relieved after the removal of localized swellings in the sternomastoid muscles. These masses consisted of thick scar tissue.

Congenital elevation of the scapula (Sprengel's deformity) is occasionally reported, but in most all instances only one scapula is involved. We have under observation at the present time a child with elevation of both scapulæ, in which there is also associated a fusion of some of the cervical vertebræ.

Cleidocranial Dysostosis.—A few more cases of this condition have been reported by Pillsbury, Krabbe and Crooke. In some of these the clavicles were totally absent, while in others the outer half of the bone was the only portion missing. The condition is often associated with other bony abnormalities, and the condition is definitely hereditary in most of the cases. Thus, Fargo reports seventeen cases in three generations.

Arachnodactylia.—This is a rare condition first described by Marfan in which there is a great increase in length of the fingers and toes, especially of the distal phalanges. The condition is sometimes called dolichostenomelia. About twenty cases of this condition have been reported (Carrau).

Congenital Contractures.—Contractures of the fingers are relatively frequent and are usually caused by constricting amniotic bands. Murphy reports a family in which this condition was present in about one-third of the members during the course of several generations.

Congenital Dislocation.—Congenital dislocation of both knees has been reported by Grossman. Two forms of this deformity occur: (1) Those due to intra-uterine pressure, which are characterized by hyperextension of the knees rather than a true dislocation; and (2) those due to true dislocation with displacement backwards of the condyles of the femur. He reports a case in a child of seven days. Bristow observed a child with congenital dislocation of the patella.

Osteogenesis Imperfecta.—This condition which is rarely observed, especially in viable infants, is characterized by the tendency to develop spontaneous fractures. Klaften mentions a few cases in which there appeared to be a familial tendency to defective bone formation. Fahr observed an abnormal maturity of the endocrine system in a case which he studied. Welz and Lieberman report a case occurring in single ovum twins.

Chondrodystrophia Fetalis.—A considerable number of cases of this disease have been observed in the last few years. These reports merely describe the bone changes found in this disease, and offer no new theories as to the etiology.

Congenital Hypertrophy.—Congenital hypertrophy of portions of the body are not as uncommon as one would suppose, especially if one takes into consideration the mild hypertrophies of certain members which frequently pass unrecognized. Hemihypertrophy has been reported some fifty times (Krostoska). The condition may be the result of congenital vascular derangement such as nevus formation with resulting oversupply of blood. In other cases the condition may be due to a defect of the nervous system with resulting dilatation and hypertrophy of the venous trunks. Ectasia of the lymphatics is another cause, under which circumstance the term congenital elephantiasis or congenital lymphangiectatic edema is given the condition. Occasionally the enlargement is the result of pressure by tumor formation (Fenner).

Stoesser has classified the hypertrophies in the following manner:

I. True hypertrophy (macrosomia or gigantism)
  A. Congenital
    1. Partial hypertrophy
      (a) Hemihypertrophy
      (b) Crossed type of hypertrophy
    2. Total hemihypertrophy
  B. Acquired
II. False hypertrophy
  A. Congenital
    1. Milroy's disease (congenital or hereditary edema)
    2. Elephantiasis
    3. Hemihypertrophy
  B. Acquired (elephantiasis)

The true hypertrophies are those involving the skeletal system as well as the soft tissues. Such is not the case with the false hypertrophies.

THE SKIN

Livedo Reticularis.—This is a congenital anomaly of the skin commonly seen as a transitory violaceous mottling on exposure to cold. Ordinarily it is such a common manifestation that very little attention is paid to it but occasionally it becomes remarkable because it is permanent. The synonyms cutis marmorata and livedo also have been given it.

Impetigo Contagiosa Bullosa (Pemphigus Neonatorum).—This disease still continues to be very prevalent in nurseries and the literature concerning it is voluminous. Falls has reported the isolation of a staphylococcus from pemphigus lesions which fulfills all of Koch's laws. Krigbaum believes that the free alkalinity of liquor cresolis compositus may be a factor in the causation of the condition and suggests that it be titrated for free alkalinity. The source of the infection may be the maternal vaginal tract, or the hands of attendants. Certainly anyone with an active pustular skin lesion should not be allowed in the nursery nor should attendants with infections of any sort be permitted access to the nursery. In a recent epidemic more or less generalized in several hospitals at one time there was an epidemic of impetigo contagiosa in the older children of the community at the same time. The pernicious habit of allowing children to visit newly born babies should not be permitted. Many remedies have been advocated, among the more recent ones the dyestuffs, such as mercurochrome—220, gentian violet, brilliant green and crystal violet. They seem to be of no more value than some of the older remedies.

Fat Necrosis.—Infiltration and induration of the skin is not uncommon in infants shortly after birth. Frequently these lesions are seen at the site of forceps applications. At other times there is no history of trauma and the site of the lesion is such that injury could not cause it. Lemez confirms the view of Cruze that extreme cooling of the skin may be an etiologic factor in the formation of these lesions. There is still considerable confusion in terminology regarding these conditions in which there are areas of fat induration in the skin. The terms sclerema and scleroderma are used by some, but objected to by others. These conditions all have more or less similarity in appearance, the pathology differing chiefly in the extent of involvement.

Favus.—Marie describes a case of favus in an infant of four days, the earliest instance of this parasitic disease.

Gangrene of the Skin.—Gangrene of the skin is very uncommon. In some instances it may result from strangulation of an extremity by amniotic bands while in other cases it may be caused by embolus. De Snoo reported a case in which the right foot was involved. At first it appeared that the whole foot would be lost but apparently the deeper tissues were not involved. After a few days the skin of the foot separated and recovery followed. Prins observed a case which resulted in gangrene of the left leg and death. A few years ago we observed a similar instance. Fischer observed involvement of the right forearm and hand. Infected thrombi were found at autopsy.

THE EYE

Rhythmic, lightning-like deviations of both eyes, which occur in about one-third of all newly born infants in the first month of life, especially in the premature, should not be considered physiologic. They are the result of irritation of the motor area in the region of the eye due to the trauma of birth. Some have been able to find signs of hemorrhage in Deiter's nucleus and in the vicinity of the nuclei of the eye muscles (Dollinger).

Yudkin reports a case of congenital microphthalmia due to underdevelopment of the ciliary body and its processes, hyperplasia of the retinal tissue and lack of choroidal vascularization. As a result, the growth of the vitreous was arrested.

THE DUCTLESS GLANDS

Thymus Gland.—This gland, whose function is so little understood, shows a temporary loss of weight in the newborn, which is concomitant with the normal loss in body weight at this time. In the first two weeks of life the gland changes from the broad fetal type to the elongated infantile type due to expansion of the lungs. Boyd has found the average weight of the gland in well nourished infants to be 13 grams at birth, 20 grams at six months and 35 grams at thirteen years, while in the poorly nourished it was 8 grams at two weeks, 6 grams at six months and 13 grams at thirteen years.

There has been some doubt expressed by certain observers as to the production of symptoms by thymic enlargement. Some have gone so far as to state that they have never seen a patient manifesting symptoms of thymic enlargement in which these symptoms could not be explained in other ways. It is well known that x-ray examination of the chest may show an enlarged thymus gland in the absence of symptoms. Podalsky and Kohn have been able to detect as high as thirty-five out of one hundred with asymptomatic enlarged thymuses. However, there are a certain number of infants with enlarged thymuses in whom there are manifestations of pressure symptoms, sometimes of a dangerous nature. Whether due to pressure upon the trachea or not there is reasonable doubt. Boyd states he has never observed such a case at autopsy. More likely the pressure symptoms are produced by pressure of the gland upon mediastinal tissues or upon the recurrent laryngeal nerve. The latter pressure probably explains the brassy crow found in these cases. That these symptoms do not come on as a rule until the lapse of a month or six weeks is probably because of the initial decrease in weight. Therapeutically there is plenty of evidence that such a chain of symptoms is caused by an enlarged thymus, since radiotherapy causes rapid reduction of symptoms. At present we feel that there is too definite a link between an enlarged thymus and the symptoms of this enlargement to doubt its presence. One error frequently made is the failure to take lateral roentgenograms. It is not so much the breadth of the gland that causes the trouble as the thickness and, therefore, this dimension of the gland must be looked into before loose statements regarding its size are made.

Of late there has been an inclination by some to regard enlargement of the thymus as the cause of pylorospasm. As a result there has been a tendency to subject all newly born infants to x-ray treatment of the thymus. Our experience has not so far justified such a procedure.

Dubois's abscesses may not always be of syphilitic origin. Benjamin reports a case in which no syphilitic changes were found.

Thyroid Gland.—Maurer has found that the thyroid gland of the fetus is capable of functioning to some extent.

Congenital goiter is relatively uncommon in most localities. Wieland, however, finds it not infrequent in Switzerland. It is characterized by retraction of the head, inspiratory stridor, hoarseness, difficult and slow nursing, and swelling of the veins of the head and the presence of a palpable gland. It usually reacts promptly to iodin rubbed into the skin in the form of potassium iodide salve. Roubal, Ettinger and Miller mention the somewhat frequent association of anencephaly with goiter. Goiter can be prevented by antepartum administration of iodin.

Lohnes and Johannsen report cases of congenital myxedema. In the latter cases there was a familial tendency.

Suprarenal Gland.—Van Veen reports a case of neuroblastoma of the suprarenal gland in an eighteen-day-old infant. At necropsy the tumor was found to have metastasized in the liver.

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PREVENTIVE PEDIATRICS

SUPPLEMENTARY CONTRIBUTION

BORDEN S. VEEDER, M.D.

There are no important changes to be made in the text on Preventive Pediatrics. The viewpoint from which the book was written—pediatrics from the standpoint of the child rather than medicine—is steadily gaining acceptance.

If the book were to be re-written the importance of heredity and body type would be even more emphasized in Chapter II.

In Chapter IV, on Nutrition, the importance of nursing both breasts to stimulate the supply of breast milk should be given more emphasis.

The Infant Mortality Rate in the United States Registration Area, discussed in Chapter VII, has decreased considerably.

In Chapter VIII, the use of toxoid mixtures for immunization against diphtheria should be mentioned. The author still feels that the immunization methods against Scarlet Fever are uncertain and that immunization as a general method is not in a position to be urged.

In Chapter X, the development of Child Guidance Clinics should be discussed, although their value and make-up is still in an experimental stage. It is the latest public health "fad" for children. Much harm has already been done by their widespread development with personnel not fully qualified to see the exact nature of the problem, and by the failure to link up the question of child guidance with the general child health problem.

DISEASES OF THE DIGESTIVE SYSTEM

SUPPLEMENTARY CONTRIBUTION

FRANK C. NEFF, M.D.

HIRSCHSPRUNG'S DISEASE

Recently I have seen a typical congenital megacolon of the Hirschsprung idiopathic type, in a Negro infant dying at two months of age. The history, illness, autopsy, gross and minute anatomy of the colon make the case one of interest. It is probable that many of the cases of enlarged abdomen regarded as belonging to this type should not be so classed. True Hirschsprung's disease is rare. The incidence in childhood, under ten years of age when most of these cases are seen, is only 1 in 10,000.

Charles Lewis, two-month-old boy, premature birth, was brought to the hospital in a terminal state, in much distress as to the breathing and with a remarkable appearance of his abdomen. The abdominal outline was globular, the distention great from the costal edge to the symphysis, the maximum circumference was 19.5 inches, the diaphragm was pushed upward giving the chest a short appearance, and causing cardiac and respiratory embarrassment, with displacement of the organs of the chest. The costal angle was widened. The infant had a very shiny black skin, the muscles were thin, the veins prominent. A large umbilical hernia and a separation of the recti muscles were noticeable. Although the temperature was normal the infant had evidently been toxic and the nutrition had suffered.

The history disclosed the fact that the abdomen was abnormally large at birth, constipation beginning at that time, and both these manifestations growing steadily worse. Vomiting had always been a feature.

The autopsy revealed no apparent cause of death; there was no anatomical obstruction found in the greatly dilated and hypertrophied colon. The colon at its beginning was 36 millimeters in diameter;

20 centimeters farther along it was 55 millimeters in diameter, and at 40 centimeters it was 60 millimeters, tapering down at the distal end to 22 millimeters. Near the widened areas the wall was thicker than normal, though in a few places it was thin. The minute anatomy showed a thickening of the wall especially in its muscular coat; the mucosa had a definite desquamation of the surface epithelium, very few cells being left intact; the normal crypts of the mucosa were not distinct; the submucous tissue and the stroma were abundantly infiltrated with lymphoid and other mononuclear leukocytes.

The muscular structures of the ileum also showed some hypertrophy but to a less degree than found in the colon.

It is possible that the desquamation of the glandular epithelium is an explanation of the tendency to ulceration and perforation of the colon which sometimes occurs in this disease. No typical ulcers or perforations were found in the case reported above.

New Methods of Treatment.—In 1926, Wade and Royle, of Australia, performed a specially designed lumbar sympathetic ramisection on the left side of a nine-year-old boy with complete cure of the constipation and ill health. Since then they have added more cases and their method has been tried successfully by others, to some extent in this country. The operation is based upon the recent conception of the etiology that there is a lack of normal relaxation in the region of the anal or the pelvirectal sphincter, found in Hirschsprung's disease. The pelvirectal sphincter represents a section about 2 inches in extent at the juncture of the colon and rectum. Normally this part is always empty. The sphincteric action is due to the presence at this point of a mucous membrane arranged in longitudinal folds which become obliterated when the circular muscular fibers contract and close the lumen. When such a band is felt by rectal digital examination under an anesthetic, it is wise to dilate it by stretching with the finger or with an inflated bag, the use of which has given good results. These newer methods offer hope of definitely benefiting the child without recourse to the serious operation of exsection of the colon except as a last resort.

RECURRENT VOMITING OF THE CYCLIC TYPE

The acute attack in cyclic vomiting is usually self-limited, but it is obviously desirable to shorten the seizures so that the child does not lose so much weight nor become dehydrated nor pass into a state of

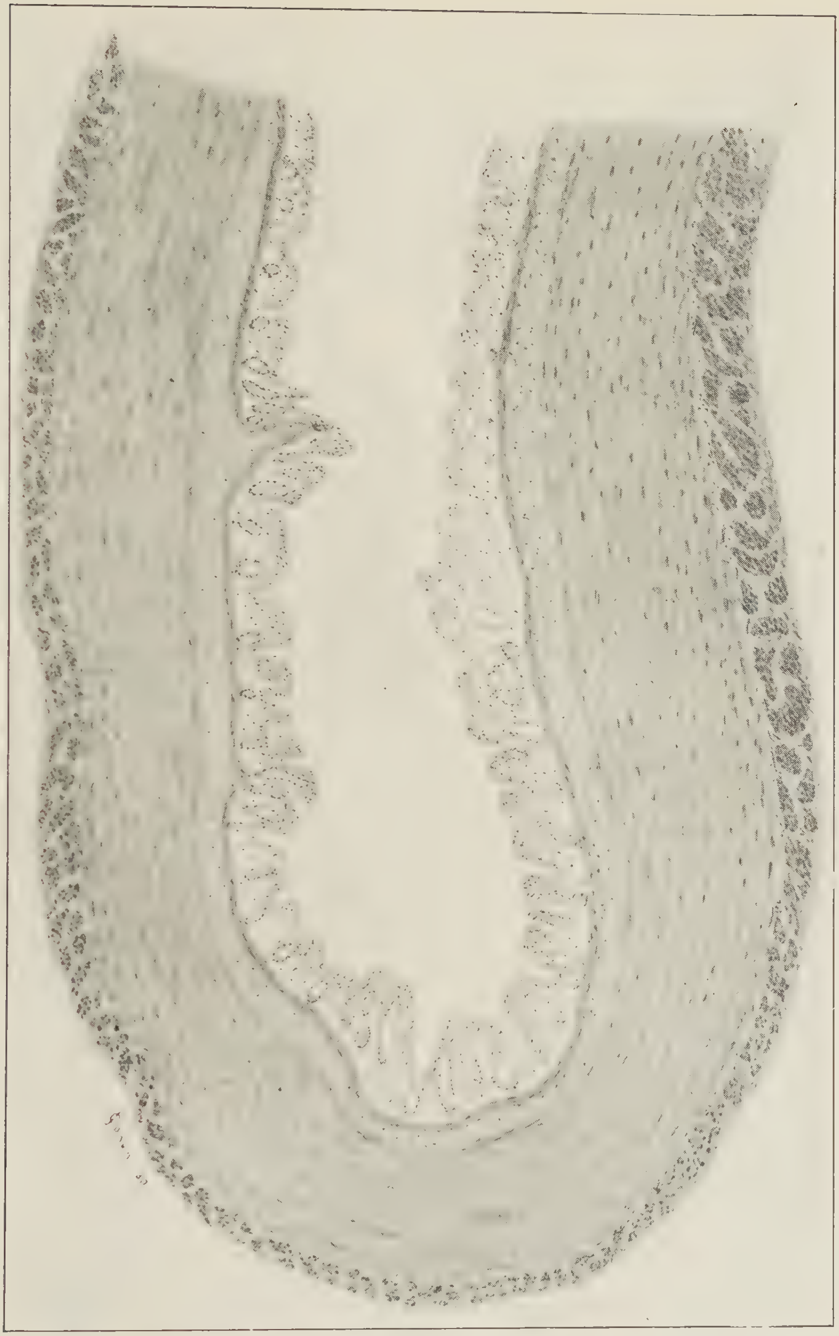

FIG. 1.—SECTION OF HYPERTROPHIED COLON (HIRSCHSPRUNG'S DISEASE).

Drawing made from the intestine of an infant two months old, whose abdomen had been enlarged since birth. Autopsy revealed a case of true idiopathic type. Histologically, the colon shows the greatly thickened muscular coat, and the poor development of the epithelium lining the glands. The mononuclear cells in the stroma are more apparent than in the normal, due to the fact that the epithelial cells show a tendency to desquamation. This would explain the ulceration and perforation of the mucosa found in some cases but not present in the author's case illustrated above.

acidosis. In its treatment food or medicine by the mouth is not retained. Hypodermoclysis of Ringer's solution is of value. Glucose and insulin by vein, as mentioned in Volume VIII, have been found to be of benefit. The following case had a typical history of recurrent vomiting but the acute attack which I witnessed had in addition other determining factors but it responded promptly to intravenous treatment:

Lois E. had had two attacks each year since the age of two at which time she would vomit for several days. When she was six years old she was brought into the hospital in coma, with contracted pupils, sunken abdomen, having vomited for 48 hours. Her breath was sweet, the breathing of the air-hunger type, the white blood count was 24,000, of which 90 per cent were polymorphonuclears, the temperature was 101° F.; there had never been polydipsia or polyuria, and the urine was always sugar free. However, the urine did contain much acetone and diacetic acid. The blood findings were positive for acetone, the CO_2 was almost too low to read, being 15 vol. per cent, and the blood sugar was 189 milligrams per 100 c.c. of blood; the non-protein nitrogen in the blood was 61 milligrams; the urea-nitrogen was 32.5 milligrams. The blood findings, therefore, were chiefly indicative of a blood concentration due to continued severe vomiting.

The treatment used seemed to be very effective. Glucose solution was given by vein, followed in a few moments by 5 units of insulin, the glucose being used as a buffer to prevent shock (1 gram glucose for each unit).

When seen about 21 days after the attack the skin was found to be peeling off especially on the soles of the feet, the cervical glands were enlarged. The mother felt sure that there had been no rash before coming to the hospital but the tonsils had evidently been badly infected.

The foregoing attack in a child with a history of cyclic vomiting may not have been due to it alone as it seems to have followed a mild scarlet fever. With the increased retention of waste products in the blood and its fairly high sugar content, the acidosis could not be laid at the door of the cyclic vomiting alone. One of Greer's cases is much similar to mine. It has been my experience that some of the attacks, which, according to the history, seem clearly to belong to recurrent vomiting, may prove to be from a combination of causes.

Air-hunger, acidosis, abnormal sugar content suggest that the above narrated attack may have been due to a diabetes without glycosuria, a fact which is known to clinicians. It would be interesting to learn in the vomiting and ketosis of those cases of the cyclic type whether the blood sugar and nitrogen are always high at the time of the seizure. There could be no harm in the early careful administration of glucose and insulin, meritorious treatment which has not yet become as common as it deserves.

CHRONIC ULCERATIVE COLITIS

One of the cases whose history I cited in Volume VIII had perforation of the rectum, due to the deep extension of the ulcer. At that time I did not however stress the symptom of perforation in this disease. Bargen, in 1929, reported 22 cases of perforation among 647 cases. Occurrence of such a catastrophe is a serious complication, as there is little that can be done for the child when such has happened, for ulcerations are numerous and the intestinal wall badly infected. Therefore, prophylaxis should be undertaken at the earliest date to prevent perforation by an ulcer.

In order to prevent this severe accident in chronic ulcerative disease, the colitis must be recognized and treated early, best by the use of a proctoscope. Whenever a child has pus, diarrhea and bloody discharge from the bowel, not of the acute dysenteric type, it should suggest ulcerative lesions and be treated at once. The earlier the recognition and treatment, the less chance for the dangerous complication of perforation.

VOMITING OF FUNCTIONAL ORIGIN IN NEWBORN INFANTS

In the nursery service of the newly born infants where large numbers of babies are observed, it is found that vomiting is fairly common. If the child is weak or premature there is still more of a tendency to vomit. It occurs especially after the first day and up to the sixth day of life. In some cases the milk runs out of the mouth, due to regurgitation. This keeps up until the infant acquires the use of the muscles concerned in swallowing. In other instances the food is ejected with some force. Vomiting can happen in well-nourished infants without any bad consequences. Premature babies, however, may lose considerable weight and, because of their poor nutrition and their lowered resistance, suffer unusually from loss of food, all of which may result in serious infections. On the contrary, infection may be the cause of the vomiting and the source should be determined, so that it may be stopped.

Among the infants in our obstetrical nursery we frequently see instances of functional vomiting. In this group only those infants are considered who are fever free, have no infection nor obstruction, no intestinal disturbance; they are supervised carefully as to the proper amount and intervals of feeding. We find that there are such infants who vomit every day for the first 3 or 4 days or irregularly during the first two weeks, sometimes every day for most of the newly born period.

The treatment which has been found of great value consists of lavage with salt solution before one or more feedings each day; the use of concentrated acidulated food or concentrated breast milk. On each day that the infant shows a tendency to this functional type of vomiting, hypodermoclysis is given to replace fluids. Ringer's or salt solution is advisable each day until the vomiting is under control. The amount taken by an infant in this condition is remarkable, sometimes as high as 500 c.c. on the first day of vomiting; a smaller amount may be taken up daily thereafter as the tissues become better supplied with fluids.

COMMON METHOD OF INFESTATION WITH INTESTINAL PARASITES

Probably few persons realize what the menace really is to the child who eats dirt. This habit or tendency is fairly common and may be harmless in localities where the soil is not polluted, but when dogs, cats, pigs, and chickens are kept in the yard where children play, large numbers of ova which are passed by the bowel of these domestic animals cause the soil to be highly polluted. There is also a danger to young children who simply contaminate the hands and clothing in such ground.

The ova of Ascaris and Trichuris develop completely in from 15 to 40 days, when the embryos are fully formed and motile. Pollution from human and pig stools is common and according to Brown the soil eventually is thickly infested with the eggs. All authors agree that the ova are hardy and may remain in the superficial ground and be pathogenic for months and years.

In the veterinary schools, in recent years, there has been developed a technic for the isolation of parasitic ova from the soil. Ova will grow in soil as deep as 5 inches when the dirt has been planted with human infested feces, exposed to the rain and carried through the soil by settling.

The method of soil examination as recommended by Brown is as follows:

The upper quarter of inch of contaminated soil is separated from the eggs by the flotation method which requires a solution of high specific gravity, so the eggs will float but the soil will not. The surface of the film is placed upon a slide, covered with a glass slip, the eggs being classified as to their kind. Feces is carried widely over the ground by insects or rain. In sandy soil the eggs probably do not retain motility so long as formerly thought.

Ascaris, the most usual of parasites, as well as other common varieties, is spread by soil infestation with human fecal matter. As a matter of prophylaxis it would be well for surveys to be made in cities, school grounds, parks, etc., for the determination of what menace there may be to children playing in such places.

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DISEASES OF THE BLOOD AND BLOOD-BUILDING ORGANS

SUPPLEMENTARY CONTRIBUTION

WILLIAM PALMER LUCAS, M.D., AND ALFRED H. WASHBURN, M.D.

Out of the mass of literature on blood diseases during the past three years the authors have attempted to record only those findings or ideas which seemed to be susceptible of practical application at the present time. Further study and experience have also dictated the adding of some of the supplementary material included here. We have arranged this data under the same chapter headings which are contained in the original volume.

METHODS OF BLOOD EXAMINATION

Oxidase Stain.—A convenient method for producing a combined oxidase and Wright's stain has been described by one of the authors (*J. Lab. & Clin. M.,* Dec. 1928, 14: 246). This enables one to do a routine differential leukocyte count, as with Wright's stain alone, and at the same time to determine both the number and type of cells containing oxidase granules. (See also Volume XI, page 29.)

Blood Grouping.—During recent years there has been a great deal of discussion in regard to the various classifications proposed for the four groups of human blood. Although the Moss and Jansky terminologies are still most commonly used, the Landsteiner or International grouping has received sufficient attention to warrant its inclusion in any presentation of the subject. This is based on the work of Landsteiner, von Dungern and Hirschfield, Ottenberg and others, who have shown that inheritance of human blood groups follows the mendelian law of heredity. The factors inherited have been demonstrated as specific agglutinins in the sera and equally specific agglutinogens in the red blood corpuscles. Thus the cells of Group 1 (Moss) contain an agglutinogen designated as "AB," the cells of Group 2 contain "A," those of Group 3 contain "B," and the cells of Group 4 (Moss) containing no agglutinogen are designated as "O." In the same way the serum of Group 1, showing no agglutinin, is referred to as "o," that of Group 2 has "b," Group 3 contains "a," and Group 4 serum contains an agglutinin designated as "ab." The complete correlation between the Moss, the Jansky, and the International groupings may be seen from a study of the accompanying table. (See also Volume XI, page 30.)

Chart of Human Blood Groups
Correlating Moss, Jansky and International
or "Landsteiner" Groupings

SERA			CELLS			
MOSS			1	2	3	4
	INTERNATIONAL agglutinogens → agglutinins ↓		AB	A	B	O
		JANSKY	IV	II	III	I
1	o	IV	—	—	—	—
2	b	II	+	—	+	—
3	a	III	+	+	—	—
4	ab	I	+	+	+	—

Since about 70 per cent of the accepted hospitals in America use the Moss grouping it would seem wise to avoid confusion by using this terminology. This table may then be used for reference in transposing to either Jansky or International groupings or in figuring out the possible inheritance of agglutinins or agglutinogens.

BLOOD PICTURES IN DISEASES OUTSIDE OF THE HEMATOPOIETIC SYSTEM

Chronic Infectious Diseases.—The blood picture in tuberculosis has received considerable attention during the past few years. As early as 1925 Cunningham, Sabin and others had pointed out the rôle played by the monocyte in tuberculosis. They showed that the injection of tubercle bacilli in rabbits was followed by an overproduction of reticular cells which developed into the large epithelioid mononuclear and giant cells so characteristic of tubercle formation. In 1928 Cunningham and Tompkins and Rogers suggested that there was a definite clinical value to be derived from these studies since the monocyte-lymphocyte ratio in the circulating blood might give reliable information as to the activity of the tuberculous process. In 1929 Blackfan and Diamond (*Am. J. Dis. Child.*, Feb., 1929, 37: 233) published the results of their studies on the blood of a group of infants and children suffering from tuberculosis. They concluded that a study of the blood with supravital technic gave both diagnostic and prognostic assistance in childhood tuberculosis. A high monocyte-lymphocyte ratio seems to be characteristic of the disease; an increasingly high ratio points to extension of the process; and reversal of this ratio signifies healing of the process. These authors stress also the importance of the presence of "modified monocytes and epithelial cells" as characteristic of tuberculous cases in contrast to such diseases as syphilis, pneumonia, Malta fever and infectious jaundice in which there may also be a relatively high monocyte-lymphocyte ratio.

Although the technic of this examination of the blood does not lend itself to use by the busy practitioner yet it must be borne in mind as a valuable aid which is available in selected cases. (See also Volume XI, page 53.)

SECONDARY ANEMIA TREATMENT

Intraperitoneal Transfusion.—In cases of severe anemia for whom a series of small transfusions are advisable there can be little question that the intravenous route is the method of choice. On the other hand intravenous injections, even of citrated blood, are not always easy or even feasible for use in the office or home. Consequently, the increasing use of intraperitoneal injections of citrated whole blood deserves some mention. The technic is extremely simple, as for any intraperitoneal injection, and can be carried out readily in the patient's home. It requires also a minimum equipment consisting of one needle of large bore and with a short bevel for the intraperitoneal injection; a regular intravenous needle for taking the blood; a large glass syringe which may be used for taking the blood and then as a gravity apparatus for the injection; a length of rubber tubing for connection between the syringe and intraperitoneal needle; and a small amount of freshly prepared sodium citrate (2.5 per cent solution) which should be placed in the syringe (10 c.c. per 100 c.c. of blood) before drawing in the blood from the donor. Untoward results are very unusual provided the routine aseptic precautions are carried out and provided the blood is carefully grouped as for intravenous transfusion. (See Volume XI, page 30.) The resulting improvement in the anemia is usually prompt and satisfactory. The authors feel that intraperitoneal transfusions provide a reliable method for the treatment of all but the very severe or emergency types of anemia in the average routine pediatric practice. In hospital work we still advise the intravenous route since we believe that the resulting improvement is maximum with this method. Cole and Montgomery have published an excellent review of the subject. (*Am. J. Dis. Child.,* Mar., 1929, 37: 497) together with their results in treating 117 patients who showed varying degrees of anemia. See also Volume XI, page 68.

Iron Therapy.—Reference has been made to Whipple's work on experimental anemia in dogs. The reader is referred to a more recent article on the comparison of various food stuffs as regards their ability to increase the hemoglobin in the body. (*J. Am. M. Ass.,* Sept., 1928, 91 : 863.) His tabulation of foods is most instructive, especially in regard to the value of apricots, peaches, apples, and prunes which surpassed both the green vegetables and beef. Whether these findings are all strictly applicable to humans or not the fact remains that the dietary of an infant or child with anemia should include as many iron-containing foods as possible. Our own experience has been that the addition of these fruits in generous quantity with the inclusion of whole liver, kidney, red meats, green vegetables and eggs gives good clinical results. This is particularly true in the nutritional type of anemia with a relatively low hemoglobin and an apparent iron deficiency. (See also Volume XI, page 69.)

IDIOPATHIC ANEMIAS

Pernicious Anemia.—Only scant mention is made, in our original article on pernicious anemia, of Minot's work on the curative power of liver. Since his original article (*J. Am. M. Ass.,* Aug., 1926, 87: 470) there has been so much work on liver and liver extract, and so much publicity given to the remarkable benefit derived from liver therapy that it has become a matter of common knowledge. This same curative substance has been shown to exist also in kidney, brain and stomach. (See Sturgis, C. C. and Isaacs, R.: Desiccated Stomach in Pernicious Anemia, *J. Am. M. Ass.*, Sept., 1929, 93: 747.) The rapid blood regeneration which takes place has been used as a therapeutic test of the correctness of the diagnosis. In typical cases of the disease there is a sharp rise in the reticulocyte count which starts within 2 to 4 days of the onset of the treatment and may reach a figure of 25 to 50 per cent of all the red cells, by the end of the first week. As the total number of red corpuscles increases rapidly during the first 3 to 4 weeks, the reticulated red cells decrease, reaching their normal level of 0.5 to 1.0 per cent when the red cell count has increased to four or four and a half million.

There is no reliable evidence that this specific substance extracted from the liver is of any particular benefit in other forms of anemia. (The anemia of sprue and that associated with *Dibothryocephalus latus* infestation are possible exceptions.) The benefit derived from whole liver in secondary anemias is probably dependent largely upon its hemoglobin-building power rather than upon any specific substance affecting red cell regeneration.

The authors wish to reiterate their assertion that pernicious anemia rarely, if ever, occurs before the twelfth year of life. Therefore, the problem of specific treatment is one which concerns the pediatrician very little. On the other hand, whole liver will be found to be an excellent addition to the dietary of children suffering from almost any type of secondary anemia. (See also Volume XI, page 93.)

Idiopathic Anemia of the Newborn.—During the last few years there have been a number of reports of cases of severe anemia in newborn babies. No consistent findings have been reported as to possible etiological factors involved. Pallor has been the chief presenting sign, while in a few this has been masked by jaundice during the first few days of life. Increasing pallor and weakness and failure to gain normally seem to be the chief evidences of disease which these babies show. Some enlargement of spleen and liver may be present. Both the red cell count and the hemoglobin percentage may be markedly reduced but there seems to be no consistent finding as far as the leukocyte picture is concerned. A recent report by Happ (*Arch. Pediat.*, Mar., 1930, 47: 171) gives a description of a typical case, together with a complete bibliography. The prognosis is serious but certainly not hopeless if adequate treatment is given early. Repeated small transfusions seem to give the most prompt and satisfactory improvement. These babies should be carefully observed during their infancy and more than usual attention given to the iron-containing foods already mentioned under the discussion of secondary anemias.

ANEMIAS ASSOCIATED WITH DISTURBANCES OF THE SPLEEN AND LYMPH-NODES

Splenic Anemia.—In this miscellaneous group of anemias one is always hoping to find some definite disease entities which may be clearly separated from the heterogeneous collection. It is this temptation which has led to such terms as von Jaksch's anemia and Banti's disease. (See Volume XI, pages 98 and 99.) A more recent attempt to define such an entity has been made by Cooley. His first description was under the title of von Jaksch's anemia (*Am. J. Dis. Child.,* May, 1927, 33: 786). Subsequently he described the unusual bone changes with anemia and splenomegaly. (Cooley, Witwer and Lee. *Am. J. Dis. Child.,* Sept., 1927, 34: 347.) In 1928 under the title of "Likenesses and Contrasts in the Hemolytic Anemias of Childhood," he grouped this type of anemia with hemolytic icterus and sickle-cell anemia, coining the term "erythroblastic anemia of childhood" for the entity which he had originally described as von Jaksch's anemia.

The essential characteristics of this form of anemia may be outlined as follows: (1) a familial (not hereditary) tendency; (2) an insidious onset with increasing weakness and pallor of a peculiar yellowish tint; (3) a moderately severe anemia with splenomegaly; (4) an unusually large percentage of immature and nucleated erythrocytes in the circulating blood; (5) a thickening of the medullary portion of the skull bones with cross striations between the two plates, demonstrable with the Roentgen ray; (6) changes in the roentgenograms of the metaphyses of the long bones consisting in rarefaction with finely stenciled cross and diagonal striations. The most constant of these findings are the erythroblastic type of anemia, splenomegaly, and long bone changes.

A number of similar cases have been reported by other authors, including Whipple and Hitzrot, in a symposium on surgery of the spleen. (*Ann. Surg.,* Sept., 1928, 88: 335.) Hitzrot stressed the remarkable and persistent increase in the numbers of nucleated red cells following splenectomy in these patients. At the present time it does not seem possible to state whether this is a real disease entity or whether it is a symptom-complex which may be produced by a number of different diseases causing a hemolytic type of anemia. Recently the authors have been following a patient whose blood showed this type of erythroblastic anemia and whose long bones showed changes identical with those described by Cooley. The finding of the parasites of tertian malaria in his blood stream and his marked improvement under quinin therapy suggests that, in this case, the syndrome was secondary to his malarial infection. Such a case tends to make one consider this disease-picture described by Cooley as "erythroblastic anemia of childhood" merely one of the possible symptom-complexes sometimes found in this group of anemias with splenomegaly. (See also Volume XI, page 101.)

Gaucher's Disease and Niemann-Pick's Disease.—In our original discussion no attempt was made to differentiate between the type of splenomegaly described by Gaucher and that of Niemann and Pick. Reference was made to two cases described by Knox, Wahl and Schmeisser as examples of Gaucher's disease. As was subsequently claimed by Downey and Mandelbaum (*Johns Hopkins Hosp. Bull.,* Apr., 1916, 27 : 109) these were really cases of Niemann-Pick's disease rather than Gaucher's. A most complete discussion of the differential points in these two diseases was presented by Pick. (*Med. Klin.,* Sept., 1927, 23 : 2, 1483.) Since Gaucher's disease is rare in early life while Niemann-Pick's disease always occurs during infancy it seems wise to summarize the chief points stressed by Pick.

Both diseases are produced by a disturbance in lipoid metabolism which causes lipoid deposits in various cells of the body. In Gaucher's disease these consist of kerasin, while in Niemann-Pick's disease they are lecithin (phosphatid). In the former disease they occur almost entirely in the reticulo-endothelial cells and primarily in the spleen, while in the latter their distribution is much more widespread, in a greater variety of cells, and involving both lymph-nodes and liver much earlier in the course of the disease. Gaucher's disease rarely appears before the fifth year, Niemann-Pick's disease always during infancy, no cases having been reported as surviving much beyond the end of the second year. The clinical picture is similar but the enlargement of spleen and liver is more marked in Niemann-Pick's type, and lymph-node enlargement comes much earlier. This latter point may enable one to reach a diagnosis by biopsy of a lymph-node much earlier in the disease than is usually possible with Gaucher's disease.

It may be questioned whether we are justified in classing these two similar disease entities with this group of blood diseases. It seems probable that they are secondary anemias, the primary cause being associated with the disturbance in lipoid metabolism. In Gaucher's disease the only characteristic, aside from a moderate anemia, is the persistent leukopenia. In Niemann-Pick's disease this is not so constant a finding, some cases showing a moderate degree of leukocytosis with immature cells of both myelocytic and lymphocytic origin and occasional vacuolated leukocytes. The diagnosis must rest upon a correlation of the clinical and blood pictures, and, if possible, the pathological process demonstrated in the lymph-node removed at biopsy. (For an excellent review of Niemann-Pick's disease see Baty, J. M.: Lipoid Histiocytosis, *Am. J. Dis. Child.*, Mar., 1930, 39: 573.) (See also Volume XI, page 114.)

LEUKEMIAS WITHOUT LEUKOCYTOSIS

Diagnosis.—In the chapter on leukemia no mention was made of roentgenographs of the long bones as an aid to diagnosis. Definite bone sclerosis associated with leukemia was described as early as 1879 by Henck (*Virchow's Arch. f. path. Anat.*, 1879, 78: 475). This generalized diffuse sclerosing process, which is apparently secondary to the leukemia, has been described by many other authors during the last 50 years. (An excellent résumé and a complete bibliography by R. G. Karschner is contained in the American Journal of Roentgenology and Radium Therapy, Nov., 1926, 16: 405.) A somewhat different and more frequent finding consists in a raising of the periosteum of the long bones, associated with a spreading of the trabeculæ in their shafts. (See Figs. 1, 2, 3 and 4.) Karschner has also summarized the reports on these bone changes in a very interesting discussion of Roentgen ray studies of the bones in various blood diseases. (*Am. J. Roentgenol.*, Nov., 1928, 20: 433.)

In a typical case of leukemia with marked leukocytosis these findings may be interesting but hardly of great diagnostic value since the examination of the blood gives such definite evidence of the character of the disease. In cases of leukemia without the typical leukocytosis a Roentgen ray study of the bones may actually be the determining factor in clinching the diagnosis. A case recently seen by the authors may serve to illustrate such a situation. This patient was a boy of eight years who had been sick for about five months, suffering from progressive weakness and anemia following an acute respiratory infection, the exact nature of which was not known. His most annoying symptom had been pain and tenderness of the extremities which he had frequently referred to the joints. Removal of infected tonsils, adenoids and teeth, together with repeated transfusions had failed to give relief. Physical examination revealed a pale, thin, weak child who appeared seriously ill. There was moderate enlargement of the spleen, liver and superficial lymph-nodes. He had a few purpuric spots on the skin of his extremities and some tenderness over the long bones. His blood

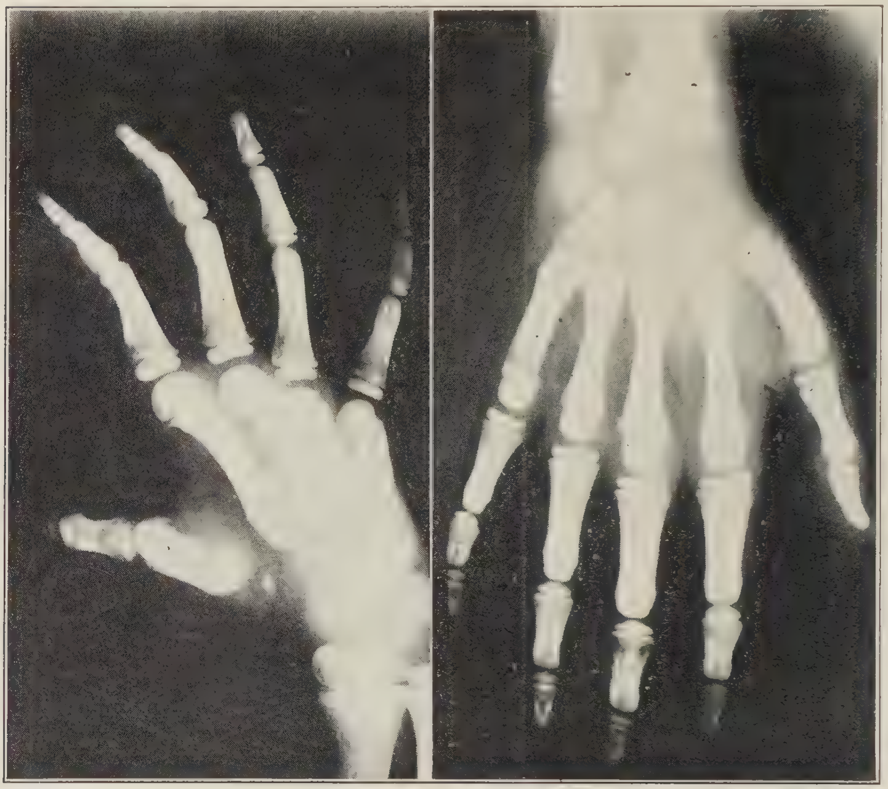

FIG. 1.—ROENTGENOGRAMS OF HANDS IN CASE OF LYMPHATIC LEUKEMIA WITHOUT LEUKOCYTOSIS.

Note spreading of trabeculæ in metacarpal bones and more especially appearance of left thumb.

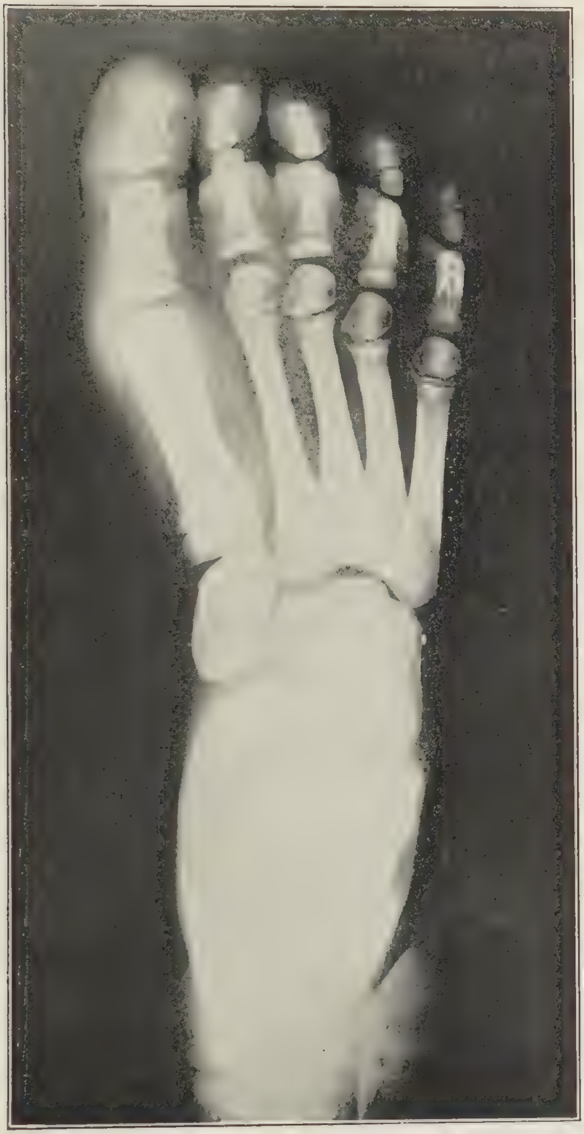

FIG. 2.—ROENTGENOGRAMS OF RIGHT FOOT OF SAME CASE AS FIGURE 1.
Note prominence of trabeculæ in metacarpals and phalanges.

showed 2,000,000 red blood cells, 34 per cent hemoglobin, 4,500 white blood cells with 18 per cent of the leukocytes polymorphonuclear or myelocytic forms and 82 per cent lymphocytic. Roentgen ray examination brought to light the typical leukemic picture. The periosteum of the tibiæ, femora, humeri, radii, metacarpals and metatarsals showed lifting in various places. There was also a spreading of the trabeculæ

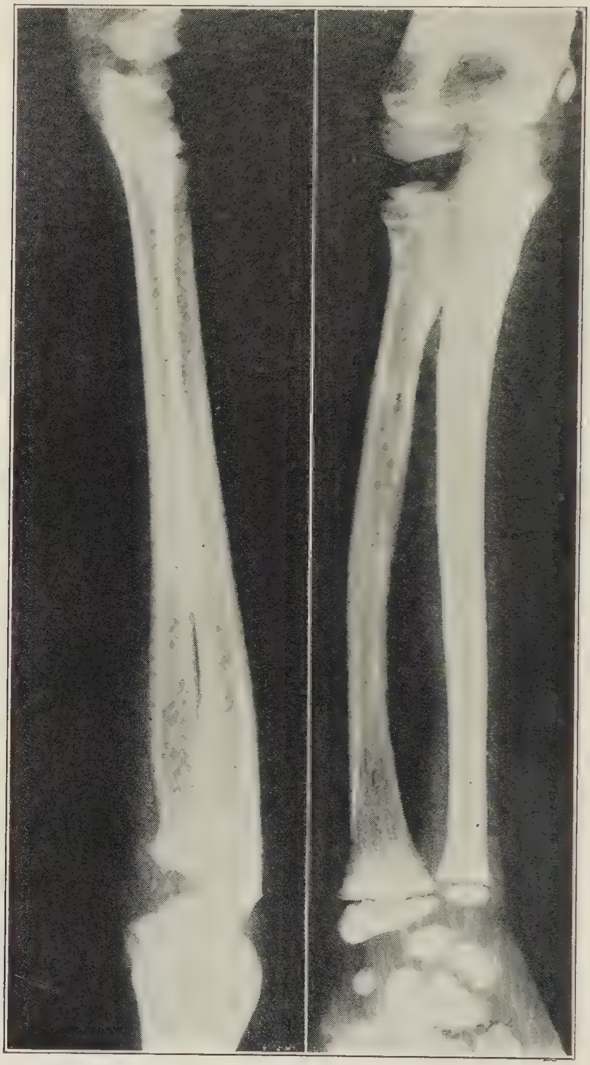

Fig. 3.—Roentgenograms of Arms of Same Case as Figures 1 and 2.

Note marked spreading of trabeculæ in right radius and lifting of periosteum on both radius and ulna.

which was quite marked in the long bones of the legs and especially so in one of the metacarpals. (See accompanying photographs.) Since this picture does not seem to be well recognized by either clinicians or roentgenologists we are particularly anxious to call attention to its diagnostic value. We believe these changes are apt to be most common in the so-called "aleukemic" type of leukemia, in which the diagnosis is obscure in such a large percentage of the cases. (See also Volume XI, page 166.)

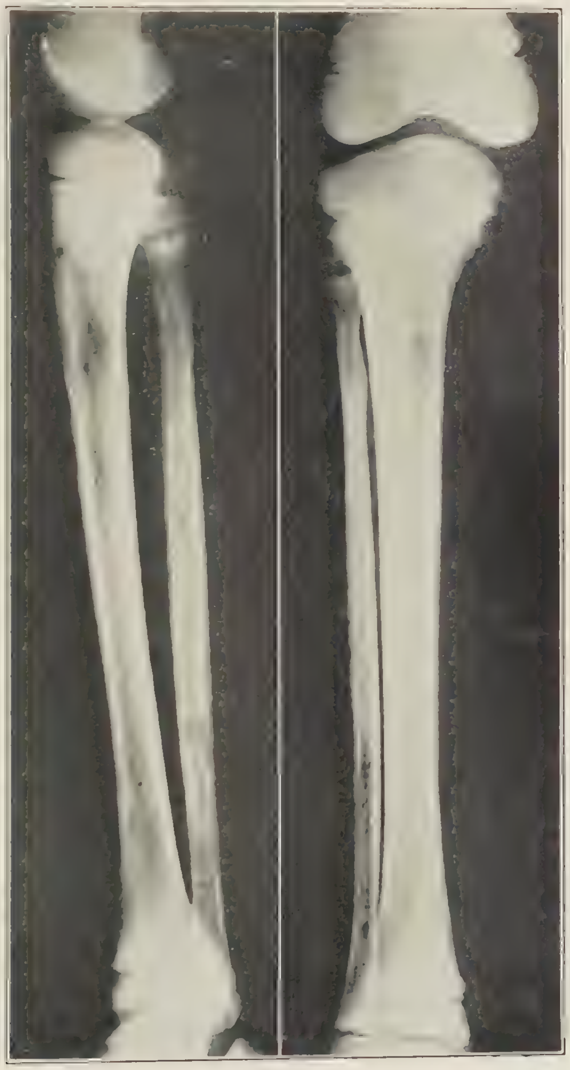

Fig. 4.—Roentgenograms of Lower Legs on Same Case as Figures 1, 2 and 3.

Note marked raising of periosteum on right fibula and spreading of trabeculæ, most marked in left tibia and fibula.

THE CHLOROMATA

Diagnosis.—The difficulty of diagnosis in this disease was brought home to the authors with unusual force by a patient who presented a characteristic clinical picture of chloroma. He had tumor nodules of the skull and facial bones with exophthalmos, a progressive anemia with slight leukocytosis and many immature white blood cells of the myelogenous series. Roentgen ray studies showed destructive lesions of the skull bones and left humerus. However, at autopsy a primary tumor was demonstrated in the left adrenal body. This whole picture was adequately described by Hutchison (*Quart. J. Med.,* Oxford, 1907), and is now referred to as Hutchison's type of neuroblastoma. Metastases to the skull and facial bones in this form of the disease are very common so that the resulting clinical picture is similar in every way to that seen in chloroma.

Unless one considers neuroblastoma, myeloma, sarcoma and Ewing's type of endothelioma in all such cases one is apt to miss the diagnosis. Pathological examination of a biopsy specimen should allow of a differentiation between the chloroma-myeloma group and neuroblastoma or endothelioma. However, even this may fail to give the diagnosis unless one has carefully considered all the possibilities (See also Volume XI, page 172.)

Treatment.—The possibility of producing more than the usually expected brief period of improvement with Roentgen ray therapy is at least suggested in a recent report by one of the authors of a case so treated. (*Am. J. Dis. Child.,* Feb., 1930, 39: 330.) This patient has shown complete relief of all symptoms and signs of the disease for three years. Whether the cure is permanent or not we feel that Roentgen ray therapy is worth further trial. (See also Volume XI, page 172.)

THE PURPURATA

Treatment of Idiopathic Thrombopenic Purpura (Purpura Hæmorrhagica).—Since Whipple's article on splenectomy in 1926 there have been several good reviews of the literature on this subject. Spence tabulated the results in 69 adults and 32 children. (*Brit. J. Surg.,* Jan., 1928, 15: 466.) Koster gave an excellent résumé of the etiology, pathogenesis, symptoms, diagnosis and operative treatment. (*Med. J. & Rec.,* 1927, 125: 23, 97 and 167.) Reuben and Claman

(*Arch. Pediat.,* Feb., 1928, 45 : 84) and Williamson (*Arch. Dis. Childhood,* Feb., 1926, 1 : 39) gave excellent summaries of the results of splenectomy in childhood. In making a report of three additional cases of thrombopenic purpura in whom the spleen was removed (*J. Am. M. Ass.,* Feb., 1930, 94 : 313) one of the authors reviewed all the cases of splenectomy reported in childhood up to 1929. Summarizing these results we find that out of a total of 50 cases, 70 per cent were completely relieved; 16 per cent were definitely improved but still showed some mild thrombopenic tendency; 4 per cent were only slightly improved, and retained in some measure their bleeding tendency; and 8 per cent ended fatally. It seems also wise to quote our conclusion that the establishment of a correct diagnosis is the chief indication for splenectomy while the existence of acute hemorrhage is the chief contraindication. (See also Volume XI, page 199.)

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